INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

All Members of the Inner North East London Joint Health Overview and Scrutiny Committee are requested to attend the meeting of the Committee to be held as follows:

Thursday, 9 November 2017 at 6.30 p.m.

C1, 1st Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG

This meeting is open to the public to attend.

	Representing
Chair:	
Councillor Clare Harrisson	**INEL JHOSC Representative for Tower Hamlets Council**
Vice-Chair:	
Councillor Susan Masters	INEL JHOSC Representative for Newham Council
Members:	
Councilman Christopher Boden	INEL JHOSC Representative for City of London Corporation
Councillor Ann Munn	INEL JHOSC Representative for Hackney Council
Councillor Ben Hayhurst	INEL JHOSC Representative for Hackney Council
Councillor Yvonne Maxwell	INEL JHOSC Representive for London Borough of Hackney
Councillor Anthony McAlmont	INEL JHOSC Representative for Newham Council
Councillor James Beckles	INEL JHOSC Representative for Newham Council
Councillor Shiria Khatun	INEL JHOSC Representative for Tower Hamlets Council
Councillor Muhammad Ansar Mustaquim	INEL JHOSC Representative for Tower Hamlets Council
Deputies	

The quorum for this body is the presence of a member from each of three of the four participating authorities.

Contact for further enquiries:
Daniel Kerr, Strategy, Policy and Performance Officer,
Tel: 0207 364 6310
E-mail: daniel.kerr@towerhamlets.gov.uk
Web: http://www.towerhamlets.gov.uk/committee

Scan this code for electronic agenda:

PARTICIPATING LOCAL AUTHORITIES

MAP OF LOCATION

1. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

2. DECLARATIONS OF INTEREST

Any Member of the Committee or any other Member present in the meeting room, having any personal or prejudicial interest in any item before the meeting is reminded to make the appropriate oral declaration at the start of proceedings. At meetings where the public are allowed to be in attendance and with permission speak, any Member with a prejudicial interest may also make representations, answer questions or give evidence but must then withdraw from the meeting room before the matter is discussed and before any vote is taken.

3. MINUTES (Pages 9 - 22)

Minutes of the meeting held on 6th September 2017

4. ITEM 4. MATERNITY (Pages 23 - 60)

This report and its accompanying summary include items covering Maternity

5. ITEM 5. WORKFORCE (Pages 61 - 80)

This report provides overview of the activity being undertaken through East London Health & Care Partnership with regards to workforce.

Travel to Tower Hamlets Town Hall Offices

By Bus

The site has excellent bus links which connect it to East and Central London and beyond.

The 277 bus route begins and ends at the site, and the 15 begins and ends a 3 minute walk away at Blackwall Station. There are a number of other bus stops close by.

Most local bus services are listed overleaf and shown on the map, with the closest bus stops clearly marked on the enlarged map below.

By DLR and Tube

East India and Blackwall DLR Stations are in the immediate vicinity of the Town Hall site, with many other DLR stations within a short walk.

The closest Tube stations are Canning Town or Canary Wharf (both Jubilee Line).

For further information visit www.tfl.gov.uk/journeyplanner

By Foot

An approximate 20 minute walk from the site is shown by the blue circle (on the map overleaf). Many DLR and both Tube stations are within this zone.

There is pedestrian access to the site from all directions, allowing good access to the surrounding area.

For more information on walking in Tower Hamlets see www.towerhamlets.gov.uk/walking

For walking directions see www.walkit.com

HEALTHY BOROUGH PROGRAMME

tower hamlets becoming a healthy borough

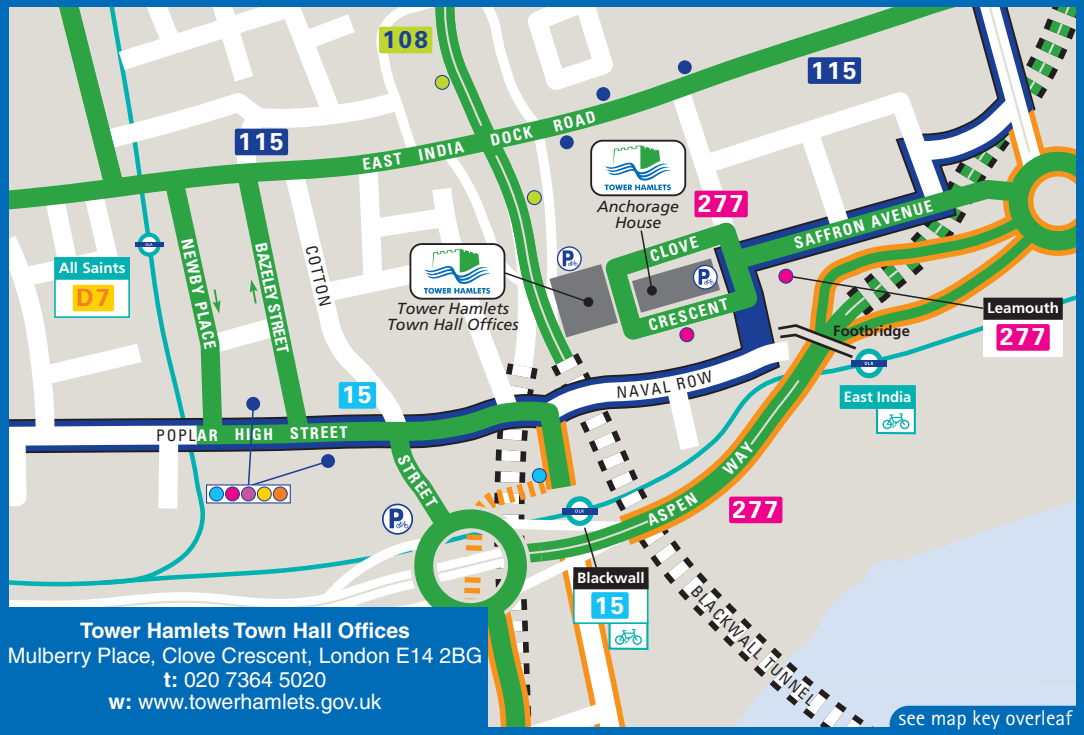
change 4 life

This map has been funded as part of the Tower Hamlets Council Travel Plan which aims to boost the number of staff and visitors travelling to the site by sustainable modes of transport.

Tower Hamlets is one of 9 areas designated as a 'Healthy Town' and has been awarded Government funding to tackle the environmental causes of overweight and obesity. Active Travel (cycling and walking) plays a major role in the programme.

www.towerhamletshealthyborough.co.uk

Design, digital cartography and print by Pindar www.pindar.com 03.10



Tower Hamlets Town Hall Offices
Mulberry Place, Clove Crescent, London E14 2BG
t: 020 7364 5020
w: www.towerhamlets.gov.uk

By Bike

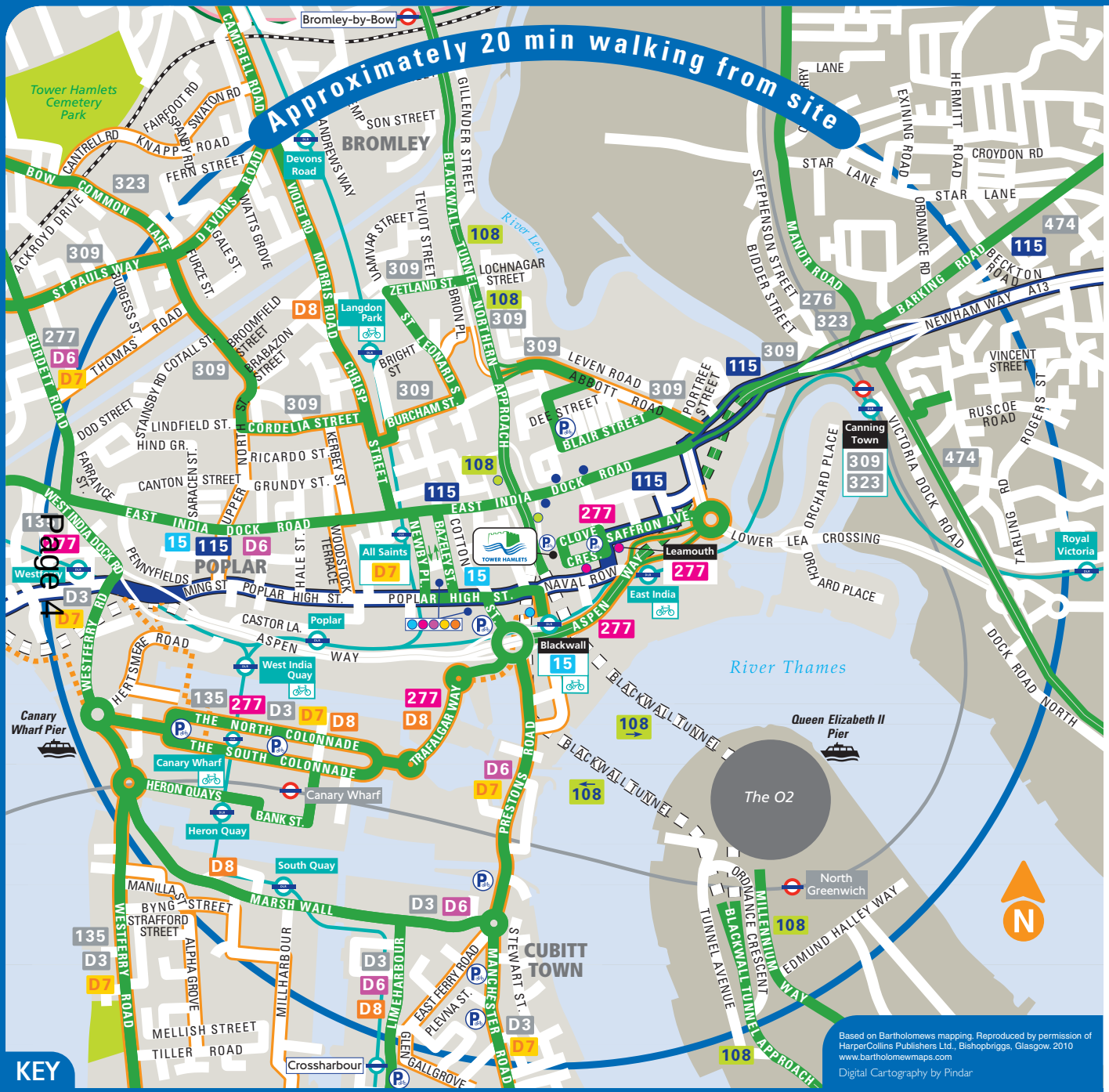
The site is well served by cycle routes, including Cycle Superhighway route 3 opening in 2010.

Cycle parking facilities for visitors are provided at ground level – see map (left).

Extensive cycling facilities are also available for staff who wish to cycle to work; email cycling@towerhamlets.gov.uk for details.

Further information on planning your journey by bike can be found at www.tflgov.uk/cyclejourneyplanner or visit www.towerhamlets.gov.uk/cycling for more information.

Map ▸▸▸



Bus Frequencies

15 Blackwall - Paddington Basin — Daily

Blackwall DLR - All Saints DLR - Limehouse DLR - Aldgate - Fleet Street - Charing Cross - Oxford Circus - Paddington - Paddington Basin

Monday - Friday daytime 6-10 minutes. Saturday daytime 6-10 minutes. Evenings and Sundays 6-10 minutes

Operated by East London

108 Lewisham - Stratford — 24 Hour

Lewisham DLR - North Greenwich - Blackwall Tunnel - Bromley-by-Bow - Stratford DLR

Monday - Friday daytime 8-10 minutes. Saturday daytime 10-14 minutes. Evenings and Sundays 20 minutes.

Operated by London General

115 East Ham - Aldgate — Daily

East Ham - Upton Park - Plaistow - Canning Town DLR - All Saints DLR - Limehouse DLR - Aldgate

Monday - Friday daytime 5-9 minutes. Saturday daytime 8-12 minutes. Evenings and Sundays 10-12 minutes.

Operated by East London

277 Leamouth - Highbury — 24 Hour

Leamouth - Canary Wharf DLR - Westferry DLR - Mile End - Hackney Central - Highbury & Islington

Monday - Friday daytime 5-8 minutes. Saturday daytime 6-10 minutes. Evenings and Sundays 9-12 minutes.

Operated by East London

D6 Hackney - Crossharbour — Daily

Hackney Central - Cambridge Heath - Bethnal Green - Mile End - All Saints DLR - Crossharbour DLR - Crossharbour ASDA

Monday - Friday daytime 6-10 minutes. Saturday daytime 7-11 minutes. Evenings and Sundays 15 minutes.

Operated by First

D7 All Saints - Mile End — Daily

All Saints DLR - Island Gardens DLR - Canary Wharf DLR - Westferry DLR - Mile End

Monday - Friday daytime 8-12 minutes. Saturday daytime 7-10 minutes. Evenings and Sundays 15 minutes.

Operated by First

D8 Crossharbour - Stratford — Daily

Crossharbour - Canary Wharf DLR - All Saints DLR - Bow Church DLR - Stratford DLR

Monday - Friday daytime 9-13 minutes. Saturday daytime 11-12 minutes. Evenings and Sundays 20 minutes.

Operated by First

For further information call 020 7222 1234 or visit www.tfl.gov.uk

Inner North East London Joint Health Overview and Scrutiny Committee 9th November 2017 **Minutes of the previous meeting**	Item No **3**

OUTLINE

Attached please find the draft minutes of the meeting held on 6th September 2017

ACTION

The Committee is requested to agree the minutes as a correct record.

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LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

HELD AT 6.35 P.M. ON WEDNESDAY, 6 SEPTEMBER 2017

C1, 1ST FLOOR, TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON, E14 2BG

Members Present:

Councillor Clare Harrisson (Chair)	INEL JHOSC Representative for Tower Hamlets Council
Councillor Susan Masters	INEL JHOSC Representative for Newham Council
Councillor Ann Munn	INEL JHOSC Representative for Hackney Council
Councillor Ben Hayhurst	INEL JHOSC Representative for Hackney Council
Councillor Yvonne Maxwell	INEL JHOSC Representative for London Borough of Hackney
Councillor James Beckles	INEL JHOSC Representative for Newham Council
Councillor Muhammad Ansar Mustaquim	INEL JHOSC Representative for Tower Hamlets Council

Other Councillors Present:

Councillor Richard Sweden	Waltham Forest

Others Present:

Henry Black	Chief Finance Officer, TH Clinical Commissioning Group
Dr Sam Everington	Chair, Tower Hamlets Clinical Commissioning Group
Dr Prakash Chandra	Chair, NHS Newham CCG
Dr Clare Highton	Chair, NHS City and Hackney CCG

Officers Present:

Daniel Kerr	Strategy, Policy & Performance Officer
Neal Hounsell	Assistant Director Commissioning and Partnerships, City of London Corporation
Antonella Burgio	Democratic Services Officer

WELCOME AND INTRODUCTION

The Chair welcomed all Members and guests to the meeting. She introduced herself and explained her role in the meeting and then invited all parties to introduce themselves and state their role at the meeting.

Following this the Chair advised that Councillor Richard Sweden of Waltham Forrest Council had been invited to the meeting as an active observer; additionally he would be permitted to ask questions.

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Anthony McAlmont of Newham Council.

2. DECLARATIONS OF INTEREST

The following declarations were made:

The Chair declared a non-specific interest in that she was employed by UNISON union.

Councillor Ben Hayhurst declared an interest in respect of agenda items four and five in that he was a Governor at the Hommerton Hospital

Councillor Sweden declared an interest in respect of agenda item five in that his employer was managed by East London CCG

The CCG Chairs Drs Everington, Highton and Chandra declared an interest in respect of agenda item five in that they were practising GPs

3. MINUTES

The minutes of the previous meeting were agreed as an accurate record of proceedings.

PUBLIC SUBMISSIONS

The following public submissions were received:

Terry Bay of North East London Save Our NHS made a submission regarding item five outlining the following concerns:

- The proposal will reduce democratic accountability.
- A single officer will be unable to cover all elements of the role.
- The public can no longer access the Sustainability and Transformation Plans (STP) websites - all links have been broken.

- Web access of decision-making and scrutiny of STP foot print level is unavailable to the public. This suggests that public transparency has been removed.
- The proposals suggest centralisation of power
- The proposals support the views that ever larger portions of NHS services are being transferred to the private sector.

Michel Vidal presented two submissions dated August 2017 and September 2017 concerning the single accountable officer proposals (agenda item five). He highlighted the following matters:

- Statutory functions prescribed in recent Health legislation were not compatible with the operation of a single accountable officer framework.
- The proposals could not fetter discretions already granted.
- The powers conferred do not include powers to create a single body across the CCG's in East London.

Coral Jones of NE London Save Our NHS presented a submission opposing the creation of a single accountable officer framework (agenda item five) highlighting that:

- The proposal will reduce accountability
- A single officer structure could not replicate or represent the levels of engagement provided by the current structures.
- The proposal would be a top-down structure - this would undermine statutory provisions
- Legal advice has been taken regarding the duty to consult and the proposal fulfils the conditions for consultation. However no consultation has yet been announced regarding the proposal, a matter which should be addressed.
- The Accountable Care Systems Board is unelected, none the less it will be able to make binding decisions without consultation.

A written submission from Mary Burnett was received by the Committee which related to agenda item 5 and highlighted concerns that the proposal would threaten the role and scrutiny of local authorities in health service planning, and undermine the voice and influence of local people.

The Committee noted the matters of concern raised through the written and verbal submissions from members of the public that were present at the meeting.

4. EAST LONDON HEALTH AND CARE PARTNERSHIP: CONSULTATION ON PAYMENT DEVELOPMENT

Henry Black of Tower Hamlets CCG presented the report advising that the East London Health Care Partnership (the Sustainability & Transformation Partnership for East London) had intentions to consult on payment processes across the 20 partners across which all care is paid. The report illustrated the present payment system, (comprised of two parts which do not integrate well) and indicated the direction of travel.

He informed the Committee that:

- The current funding arrangements are deemed not fit for purpose in the context of the development of Accountable Care Systems (ACS) as it has multiple facets and is complex. ACS aim to improve patient outcomes and will be able to do so more effectively if payments are better targeted to help deliver improvements for patients.

- The ultimate goal of the work is to develop an integrated payment system and to deliver better outcomes; the present system is unable to achieve this due to its complexity. It is aimed that a revised payment system will ease financial pressures on more acute parts of the system, which are presently activity based, and regularise the basis of payments.

- The consultation has been initiated to seek views on the current system. The consultation aims to capture feedback which will be analysed to determine what Partners feel does and doesn't work well and this will inform proposals for an alternative payment system.

- The consultation was due to end on 30 September 2017 and views/information would be gathered and analysed.

The Committee identified matters of concern which are detailed in the following paragraphs and Mr Black offered responses outlined below:

Payments Systems Issues:
Concerning why an alternative payments system was being explored before the environment in which it would operate was known. The Committee was informed that the consultation did not propose an alternative system but sought to obtain views on how current system worked, how to remove impediments of the current system, and to explore what it could look like in future.

There was no intention to change the payment system before designing new structures unless an appetite for this was indicated by the consultees.

A prior consultation on the care system was not necessary as the consultation on the payments system was not a technical but a broad one.

The outcome of the consultation will be reported to INEL JHOSC which is being delivered via a private provider.

No potential models have been included in the consultation or report as the CCG did not wish to influence respondents towards any particular payment model.

Breadth of Consultation:
Councillor Masters noted that there had been only 50 consultees to date and felt that this was a small sample. She was advised that there had also been outreach to NHS Healthwatch organisations. Representatives of Save Our NHS challenged this information asserting that they had sought to attend consultation meetings but had not been invited. Councillor Masters reported that she had heard hear say reports to this effect. Mr Black highlighted that CCG wanted to hear from all who wished to participate in the consultation and would ensure that they were able to participate. The Chair noted the comments and asked Mr Black to liaise with the Save Our NHS group with a view to ensuring their participation.

Councillor Maxwell requested that the Committee should evidence engagement with hitherto excluded parties and that this be reported back to the Committee. Mr Black agreed to provide updates and the Chair requested that an item be added to the next agenda in this regard.

Dr Everington noting the concerns expressed around access to the STP webpages gave an undertaking that all information will be accessible by the end of October 2017.

The Chair noted the fragmentary nature of consultations brought to Committee and that they did not appear to inform a coherent strategy or approach.

Councillor Sweden commented that there was a perception that block contracts do not pay for activities and he had observed changes in spot payments to the extent that it became difficult to provide activities due to rising prices. He asked if there would be any pre-conceptions around spot purchases versus block payments and was informed that the CCG's aim was to develop a payment system which works better than that presently in use. To this end the CCG was pleased to receive relevant submissions from Councillor Sweden.

Dr Highton advised that a move away from spot purchases can be a benefit.

Councillor Hayhurst was dissatisfied with the timescales in which information was made available to consultees (he cited the late circulation of the report relating to the Single Accountable Officer (SAO) as an example) stating that the disparity in circulation of some reports was unacceptable. He was informed that reports were circulated as soon as they were available.

Councillor Hayhurst's stance was supported by the Chair and Councillor Masters noting that the Committee encountered challenges in getting reports; although matters such as SAO had been widely known long in advance, information was made available at short notice. This contributed to a sense of things feeling rushed and information made available at very short notice. Concerning how the CCG would address Members concerns around the lack of transparency, the Committee were informed that the CCG was seeking to consult as widely as possible, and any interested party was welcome to submit a response.

Scope Outcomes and Decision Making:
Councillor Hayhurst expressed concern about the nature of consultation which he felt focussed on the negatives of the matter and fostered mistrust. He enquired if this would be a single consultation or if further engagement would follow and was advised that there would be further engagements arising from the outcomes of the present consultation. It was intended that later consultations would seek views on alternatives options and these will have been informed by the feedback from the current consultation.

Concerning who will make the final decision, the Committee was informed that a Strategic Committee would consider the outcomes of consultations and then consider the direction for progress.

Concerning how the CCGs decide what commissioning model suits them and retain autonomous control, in the context of the outcome being devised by the financial strategy committee, the Committee was informed that payment by results is default but not mandatory; therefore any CCG can choose. However payment by results is the default and NHS feels there are high risks to move away from this. Notwithstanding, if the systems agree, they may choose to move away from this method.

Concerning what feedback has been given by hospitals which may have benefited from payment by results, the Committee was informed that there was much evidence that payment by results was not working for providers or commissioners. Dr Everington used the recent Junior Doctor industrial action as an example and informed the Committee that changes could free consultants to better do their job on hospital wards.

Concerning themes and issues so far identified through the consultation, the Committee was informed that general models, included; competition across a bigger footprint and prioritisation of outcomes, three-part payment and other models. The CCG was seeking to achieve a consensus of what models will access better outcomes across the elements.

The Chair thanked Mr Black for his report and asked that a further report be brought to the meeting in November 2017 outlining the findings of the consultation so far and indicating what trends and developing themes had been identified.

RESOLVED

1. That the report be noted

2. That the Committee's concerns and views be noted

3. That a report be presented at the Committee's meeting in November 2017 outlining the findings of the consultation to date and indicating what developing trends and themes had been identified.

5. SINGLE ACCOUNTABLE OFFICER FOR EAST LONDON HEALTH AND CARE PARTNERSHIP - NEW COMMISSIONING ARRANGEMENTS FOR NORTH EAST LONDON

Drs Highton, Everington and Chandra presented the report advising the committee that the context of the proposal was austerity and efficiencies. Since health was experiencing significant financial challenges it was necessary to consider how to use the resources more effectively. Local stakeholders and interested parties have been kept up to date on developments relating to the new arrangements.

The report outlined a scheme to create a Single Accountable Officer (SAO) role to act over 7 CCGs as part of a delegated governance process which will provide leadership to ensure that big changes required to support effective local commissioning are delivered.

- SAO will take the STP lead role.
- There will be new governance arrangements

The Committee heard that:

- Presently there were no models to demonstrate what Accountable Care Systems (ACS) would look like but these would be outcome focused and the introduction of the SAO was the consequence of this change.
- There would be a strict scheme of delegation and a compulsory joint committee would be established.
- NHS England wish to act through an SAO and on this basis will release money to develop an ACS. Dr Highton acknowledged that accountability at local level had been very problematic and STP had not been allowed to share information. However accountability had to remain at local level.
- The roles of STPs and CCGs would be better differentiated and a Scheme of Delegation would address a small number of matters that cannot be undertaken at local level. The local CCG would remain the accountable body and scheme would offer more opportunities to collaborate locally. Integration of the CCGs was acknowledged as difficult to deliver, however this would change the patient experience.

- The five-year plan sets out that services should be brought as close to the patient as possible. This is demonstrated by proactively managing patients' care.
- The direction of travel has three elements; more accountability; joint commissioning and pooling of resources at STP level for value for money.
- Local accountability will be retained as the position of CCG Chairs will be retained and will not change.

Members considered the report and felt that the late circulation of the document upon which the discussion was to be had and the timeframe for the feedback placed unreasonable pressure on INEL JHOSC members.

The Committee also identified many matters of concern which are detailed in the following paragraphs and Drs Highton, Everington and Chandra offered responses outlined below:

The SAO
Concerning whether there would be an internal appointment to the SAO post, the Committee was informed that the post will be properly advertised.

Concerning whether the SAO could override CCG Chairs by means of his/her direct line to NHS England, the Committee were informed that this situation would not occur as the appointment will be made by all CCG Chairs.

Concerning the air of mistrust created amongst stakeholders and interested parties arising from the timing of the initiation of the SAO role and the issues this creates around relinquishing of control upwards to NHS England, the control that will be exercised through the ACS and the sense created that control is being centralised early, the Committee was informed that:

- The SAO would relieve the burden on CCG Chairs to manage upwards (a task that currently fell to them). However it was acknowledged that the proposal reverses CCG responsiveness and powers ahead of the implementation of the new structure.
- The three East London CCGs have worked collaboratively for three years and therefore the proposed change will not create a completely new environment

Impacts of the SAO
In regard to the following observations that:

- while noting reports of Barking, Havering and Redbridge University Hospitals NHS Trust arrangements working well, the notion of one officer across diverse boroughs was not logical and was opposed to subsidiarity of East London Healthcare Partnership and

- grading of STP plans best areas are based around one local authority therefore the footprint of the proposal was illogical (since ratings of STP plans imply that the best outcomes occur where there is focus).

The Committee was informed that perfect boundaries were impossible; however totals have been applied and will enable CCGs to avoid duplication. The challenge to be met was how most (CCGs) might do all in the best way possible. It seemed therefore that relationships would be critical in determining success. Also CCGs could not operate in isolation but if they managed differentially seeking optimum levels in each area, this might produce the best outcomes for patients.

Responding to a Member observation that the creation of large Trusts would involve levels of responsibility, the Committee was informed that there were legal posts which must be appointed to.

Concerning:

- Whether a person would be able to discharge the SAO role, the Committee was informed that the role would come into being; however there was some discussion whether realistically the role will be difficult for one person to perform.
- Whether experienced roles/officers would be lost, the Committee was informed this depended on how the system develops and who is appointed. The CCG Chairs agreed that the loss of chief operating officers would be a significant loss but this was a consequence of Accountable Care which is narrow.

Responding to the Committee's continued concerns around the impact on experienced staff; the CCG Chairs highlighted the following positive aspects of the proposal:

- one voice to approach the commissioner
- less duplication in commissioning terms
- potentially better quality outcomes
- regarding loss of talented staff, there must be action to reduce uncertainty and staff loss.

Concerning whether the changes would result in patients having to travel to other hospitals for treatment, the Committee was informed that CCGs will seek to avoid the necessity for travel to other hospitals; however patient choice was a factor that needed to be taken into account as they may ask for referral for treatment to a hospital of their choice.

Lines of Responsibility
Noting the advantages that the proposed arrangements would bring, a Member observed that the SAO appears to be a form of leadership. This officer would impact the CCG system and indirectly the experience/suffering

of patients therefore an assurance was sought that the patient experience would not be negatively affected. The Committee was informed that patient suffering is determined by resources. It was acknowledged there would be a move away from accountable CCGs; however the process of transition had elements of uncertainty. Responding to this information a Member asserted that while the transition was accepted it was not clear why accountability was being passed to an SAO and the role initiated before the scope/powers of the role had still to be defined. Additionally there were concerns around what powers the post would hold and changing structure before proposals are known.

The Chair noted that local authorities wished to know and understand the reporting lines and lines responsibility below the SAO for each borough. Members were concerned that:

- borough links will be will be diluted
- the vision was based around personalities and there needed to be a basis that would ensure longevity
- there had been frequent changes in the NHS over recent years which fostered an environment of instability.

In the context of these matters there was concern that the local voice and experience will be lost. The CCG Chairs noted the issues raised and advised that the proposed joint committee would involve local councillors. Additionally the Chairs of JHOSC and of the CCG were part of the STP Board therefore local involvement could continue. They acknowledged that the function of bringing services close to its committee was not well delivered by the STP. The Chair noting the response given asserted that none the less it was necessary that accountable care should to be integrated and the system-wide voice is heard by the local authority voice – this is lost progressively as it travels up each organisational level. Dr Everington acknowledged that there were gaps and suggested that there should be a governance arrangement that covered all seven CCG areas.

Concerning how the joint commissioning would direct scheme of delegation to increase, the Committee was informed that this matter would need to be taken through CCG and have to be directed by NHS England.

Concerning what the stages and characteristics of the consultation elements would be, the Committee was informed that all further consultation will have to go through CCG Board. It was acknowledged that the changes had caused significant uncertainty however in the view of NHS England the exercise was an engagement not a consultation. Notwithstanding it was important there was good engagement at local level as this was the most effective area. To this end City and Hackney CCG had organised a number of local meetings. There had also been consultation with Health and Wellbeing Boards and Health Scrutiny. Although it was not possible differentiate engagement/consultation at local STP level, it was perceived that STP would welcome some sort of a forum with the seven local authorities affected by the

proposal. The local authorities were asked to consider what structures would be appropriate.

Councillor Masters felt that there was confusion around the governance model for the East London Health and Care Partnership and that it was complex. She asked for a structure chart to illustrate the relationships and was directed to the tabled paper/report. The Chair asked that this be brought to the next meeting.

Action by: Dr Clare Highton, Chair, City and Hackney CCG

The Committee felt that in the context of the present political instability, it was not beneficial to undertake the reorganisation at this time especially where austerity was used as a driver. This caused concern that there were cuts for cuts sake. Responding to these views, the Committee was informed that the proposals should provide some savings. CCG Chairs were not party political but were supportive of solutions which provided more resources.
Councillor Hayhurst asserted that the proposal to discontinue accountable care officers had been known and asked that proposal to support the creation of an SAO should be put to a vote.

The Chair and members supported this motion and the following vote regarding the endorsement of the paper/report was recorded.

Votes to endorse the paper/report = 0
Votes against the endorsement of the paper/report = 6
Abstentions = 1

It was noted that Councillor Sweden participated in the discussion but not in the vote.

The Chair noting the outcome then asked that a letter be drafted for the CCG meeting on 13 September 2017 stating the Committee's refusal to endorse the proposal. She agreed to sign the letter on behalf of the Committee.

RESOLVED

1. That the Committee's opposition to the proposal and the areas of concern identified (as minuted) be noted.
2. That a letter to the CCG conveying these concerns be sent to the CCG meeting of 13 September 2017.

The meeting ended at 8.35pm

Chair, Councillor Clare Harrisson
Inner North East London Joint Health Overview & Scrutiny Committee

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Inner North East London (INEL) **Joint Health Overview and Scrutiny Committee** 9thth November 2017 **North East London Sustainability and Transformation Plan; Maternity**	Item No **4**

OUTLINE

Over the course of 2017, health and care organisations across 7 boroughs in North East London (NEL) have been working to develop a draft Sustainability and Transformation Plan (STP). The STP sets out how the NHS Five Year Forward View will be delivered across the NEL footprint and how local health and care services will need to transform in order to ensure their financial sustainability and improve their clinical effectiveness.

INEL JHOSC has requested that NHS partners provide an overview of how the draft NEL STP will be developed through consultation, engagement and scrutiny processes so that the plans are given appropriate oversight and accountability.

This report and its accompanying summary include items covering Maternity, specifically:

- An overview of performance across maternity services in NEL
- Challenges and vision of maternity services in North East London.
- Governance arrangements of the East London Local Maternity System and alignment to the East London Health and Care Partnership
- An overview of the development of transformation plans and the delivery model for maternity services in NEL over the next 5 years.
- An overview of wider engagement on plans for maternity.

ACTION

- The Committee is requested to give consideration to the report and discussion and provide comments.

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East London Health & Care Partnership

ELLMS
EAST LONDON LOCAL MATERNITY SYSTEM

East London Local Maternity System

Report to the Inner North East London Joint Health Overview and Scrutiny Committee

9 November 2017

Purpose

- To set the context, challenges and vision of maternity services in North East London.
- To highlight the governance arrangements of the East London Local Maternity System and alignment to the East London Health and Care Partnership.
- An overview of performance across maternity services in NEL.
- To provide an overview of the development of transformation plans and the delivery model for maternity services in NEL over the next 5 years.
- To highlight wider engagement on plans for maternity.
- To highlight successes achieved to date.

Introduction

- In February 2016, the National Maternity Review ‘Better Births’ set out the Five Year Forward View for NHS maternity services in England, with the aim for services to become safer and more personal and kind. In response, NHS England established a Maternity Transformation Board (MTB) to oversee the delivery of the policy and recommendations.

- The MTB recognised that delivery of its vision relies on local leadership and action, and asked the system to come together to form Local Maternity Systems (LMS) to achieve this.

- Within the North East London Sector the East London Local Maternity System (ELLMS) was established with governance arrangements aligned to the East London Health and Care Partnership.

- ELLMS has now developed a detailed plan for the next 5 years to focus on how the system will coherently deliver recommendations of Better Births both individually and collaboratively, whilst recognising that implementation will require significant transformation from providers of maternity services.

- NHS England have produced a set of **Key Lines of Enquiries (KLOEs)** for all Local Maternity Systems to develop clear and credible plans and baseline data requirements ahead of an assurance submission to NHS England in October 2017.

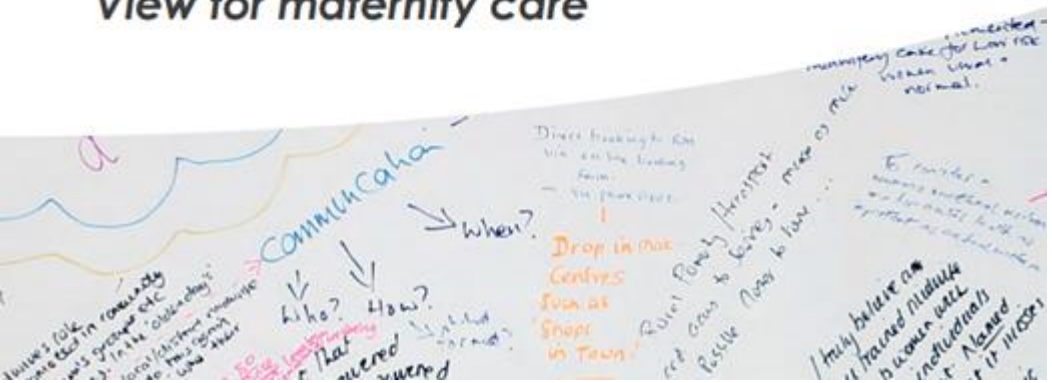
Policy Context

NATIONAL MATERNITY REVIEW

BETTER BIRTHS

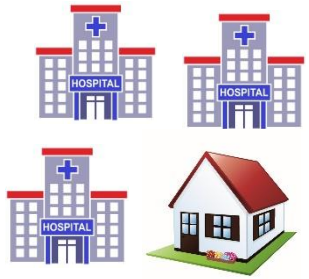
Improving outcomes of maternity services in England

A Five Year Forward View for maternity care



'Halve it' Ambition

OUR VISION FOR MATERNITY SERVICES IN EAST LONDON



Choice journey begins with services recognising women's needs

Accessible relevant information in a range of formats with options for discussion and support with referral as needed and option of self-referral

Choice discussions with midwife about options for care begin at booking

Continuity of carer close to home where possible supports personalised kind care

Choice of place of birth is offered to all with high quality, unbiased information and discussion

Optimal birth experience with known midwives and good multidisciplinary working supports improved outcomes

Transfer to postnatal care is seamless and well supported with optimal start to family life

Safe respectful care is at the centre of all we do

Integrated records support excellent clinical care, communication and safety

An empowered workforce who prioritise multidisciplinary working wraps care seamlessly around the woman

An holistic public health approach underpins care

Services are improved and designed with women not just for them

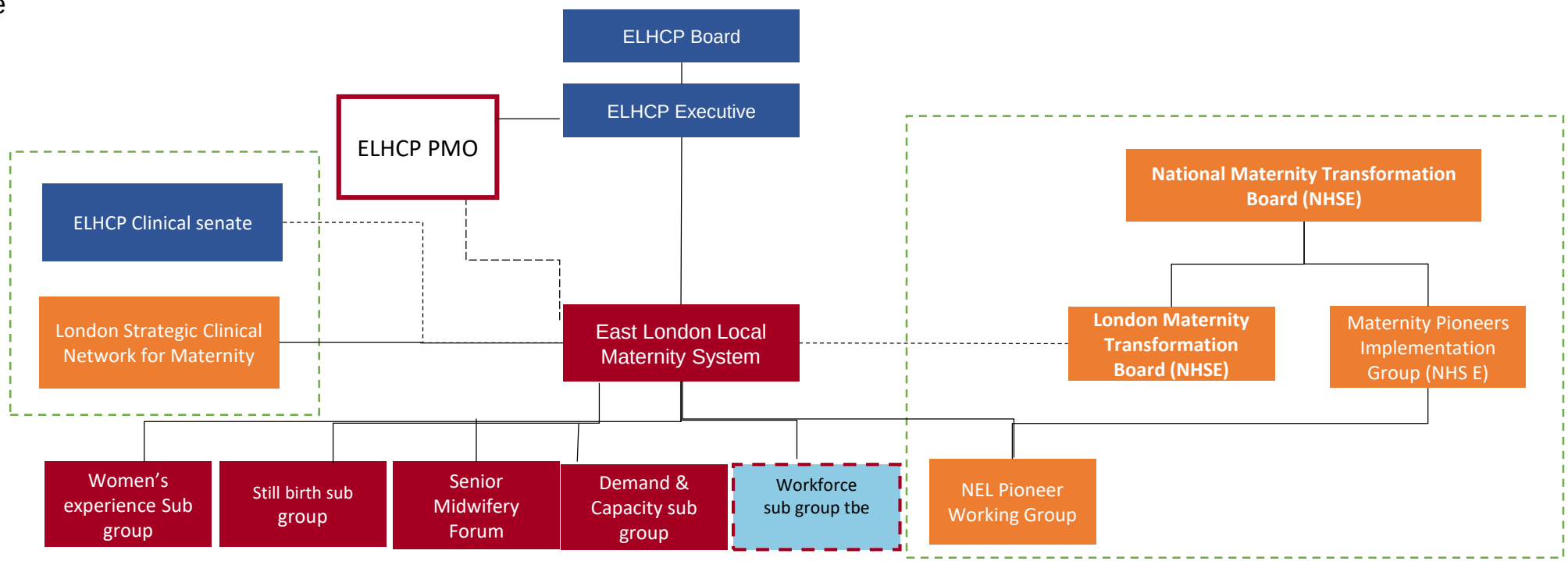
The Golden Threads

The Current Position and Key Challenges of Maternity Services in NEL

- Demand modelling indicates an increase by 4.41% (approximately 1500 births) within the next 5 years with greater pressure anticipated in the BHR footprint.
- There are 4 providers working over 5 acute sites for maternity services each with an obstetric labour ward and an alongside midwifery led unit.
- There are also two freestanding midwifery led birth units.
- One Midwifery led NHS Provider in NEL.
- Workforce gaps and high turnover of midwifery staff in acute providers resulting in challenges with clinical capacity or transformation.
- Variation exists in patient ratio to GP with Redbridge and Waltham Forest falling in the lowest 20% whilst City and Hackney and Tower Hamlets have the first and second best ratios across London.
- There is significant financial pressures on providers and a drive to achieve a sustainable future position
- 19.9% (2712) of women are presenting with multiple co-morbidities, which may rise as high as 23% by 2018
- Over the last 2 years a rise of over 2% in the numbers of women reported as unable to speak or understand English (from 6.9% to 9.3%)
- 70% of women who give birth in Newham are born outside the UK.
- 43% of women in Tower Hamlets born outside the UK with over 90 languages spoken in the borough.
- Age of women giving birth higher than national average (NEL 31.16 yrs. compared to the national average of 30.4 yrs.)
- An expected increase in the prevalence of diabetes 1.5% (1051 women) per year.
- A further 1% (254 women) of women are expected to develop gestational diabetes during pregnancy.
- Mental health conditions rising by 1% (254 women) per year

North East London Maternity Governance Structure

- Within NEL The ELLMS reports via the ELHCP Programme Management office to the ELHCP executive and Board.
- It also reports to the London and National Maternity Transformation Boards.



The ELLMS is not a statutory body and it is noted that accountability for commissioning remains with the CCGs and accountability for service provision with Trust Boards.

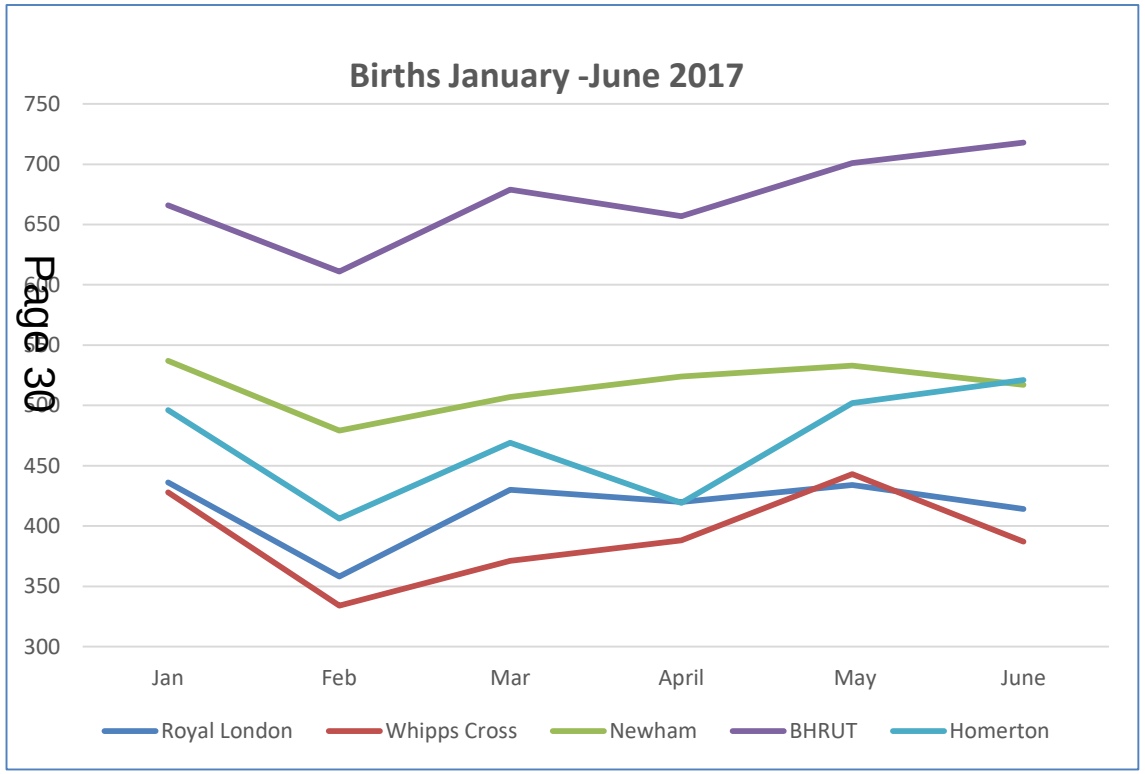
Our maternity transformation plans:

- **Reduce stillbirth/neonatal death/brain injuries and maternal death** by 20% by 2020 – and halved by 2030.
- **Investigate serious untoward incidents and share the learning.**
- Engaging with **NHSI neonatal and maternal safety collaborative**.
- Ensure more women have **a personalised care plan**.
- Ensure more **women can choose from the three places of birth.**
- Ensure that **more women receive continuity of the person caring for them** during pregnancy, birth and postnatally.
- Ensure that more women be enabled to **give birth in midwifery led settings**.

Our maternity transformation plans:

- Is based on an **understanding of the needs of local women** and their families and is it aligned to the local STP?
- Has been **signed off by** the Sustainability and Transformation Partnership (STP) Board.
- Provides evidence of a detailed assessment on the level of **capacity & capability** to implement plans.
- Detail of **how the plans will be implemented**? This means including actions and milestones (with responsible owners), how will the plan be delivered, monitored, assured and evaluated, and how interdependencies work with other work streams of the STP (e.g. Digital Roadmap, workforce) will be managed.
- **Is Costed plan and resources** within the constraints of the STP's financial balance. This includes an assessment of the need for additional financial investment the LMS has identified through its plan and the extent to which the business case is credible.
- Includes our non-clinical LMS plans i.e **Procurement, Digital and Estates transformation and workforce** transformation plans.
- Outlines our **LMS governance** and how it aligns with the STP plans.

Total Births in NEL



Provider	Jan	Feb	Mar	April	May	June
Royal London	436	358	430	420	434	414
Whipps Cross	428	334	371	388	443	387
Newham	537	479	507	524	533	517
BHRUT	666	611	679	657	701	718
Homerton	496	406	469	419	502	521
Neighbourhood Midwives	4	7	8	7	7	8

(Jan –June 2017: *Source NEL Maternity dashboard*)

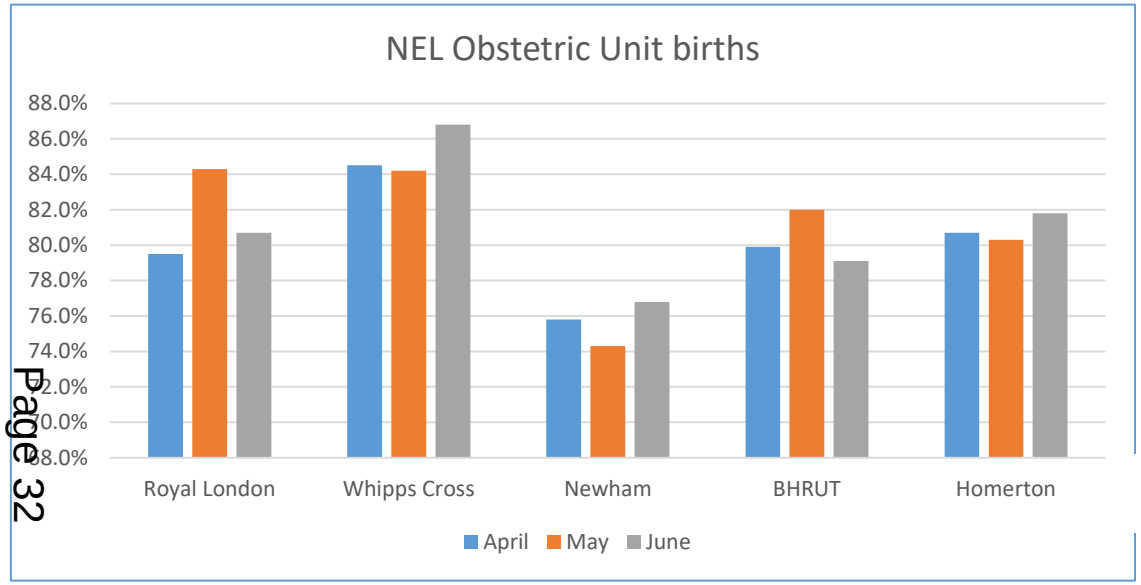
Key Headlines of our plans : Out of Obstetric Unit Births

- ❑ Data suggests that low risk women are safer giving birth in midwifery led settings and have better experiences of care
- ❑ In 2016/17 approximately 18% of births in NEL were in midwifery led settings with wide variation across providers from 13 – 25%.
- ❑ There is capacity in the system to increase these figures even in the face of rising acuity

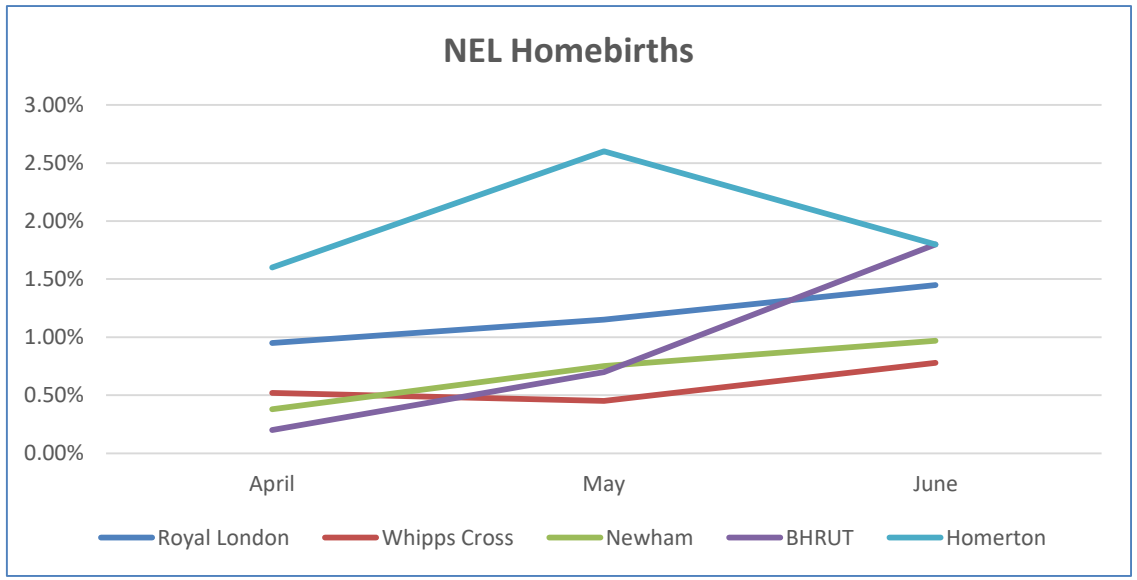
	BHRUT	HUH	Newham	Royal London	Whipps Cross
Out of Obstetric Unit Birth rate in 2016/17	18.34%	17.45%	25.3%	13.1%	15.6%
Aspirations for Out of Obstetric Unit Birth 2021	22%	25%	40%	30%	35%

2017/18	2018/19	3 + years
• Establish Out of obstetric working group/ develop outline and expression of interest documents. • Develop shared guidelines across the ELLMS.	• Develop further plans from recommendations being developed from acuity modelling in collaboration with commissioners to inform future commissioning arrangements for 19/20 and onwards.	• Agree and achieve target set by the LMS to increase midwifery led unit births to across NEL.

Our Performance on Place of Birth



NEL Obstetric Unit Births	April	May	June
Royal London	79.5%	84.3%	80.7%
Whipps Cross	84.5%	84.2%	86.8%
Newham	75.8%	74.3%	76.8%
BHRUT	79.9%	82.0%	79.1%
Homerton	80.7%	80.3%	81.8%
Neighbourhood Midwives	29%	29%	38%



INDEPENDENT

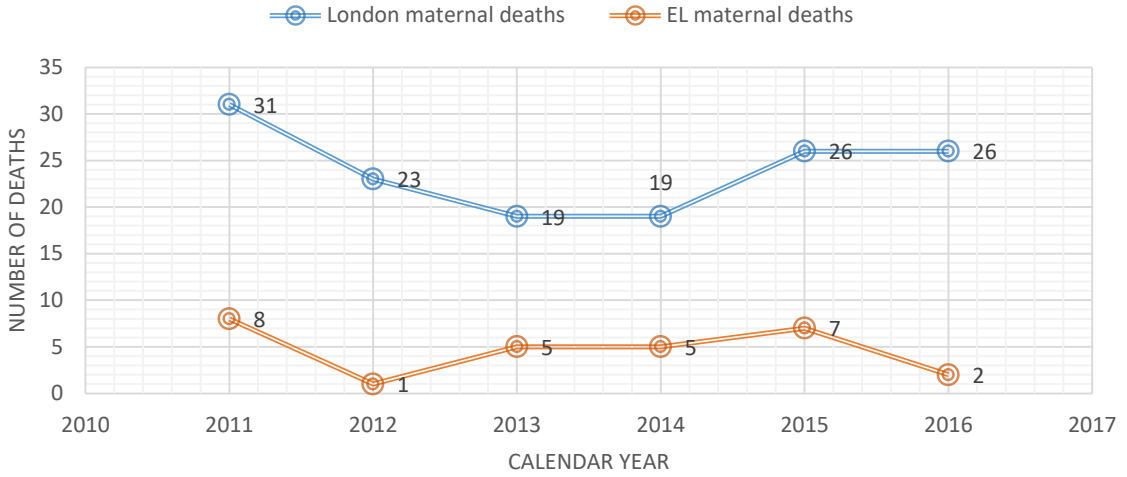
MATERNITY SHAKE-UP Maternity care shake-up could see more women giving birth at home or without doctor present

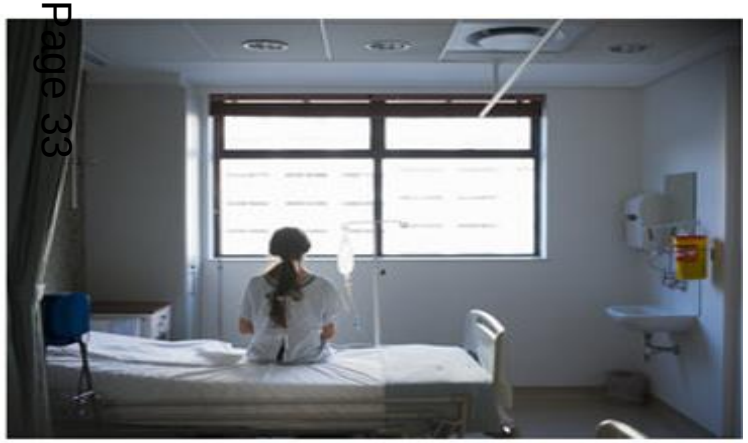
NEL Homebirths	April	May	June
Royal London	0.95%	1.15%	1.45%
Whipps Cross	0.52%	0.45%	0.78%
Newham	0.38%	0.75%	0.97%
BHRUT	0.20%	0.70%	1.80%
Homerton	1.60%	2.60%	1.80%
Neighbourhood Midwives	43%	71%	63%

Source NEL Maternity dashboard)

Safety Performance

Calendar year	London maternal deaths	EL maternal deaths
2011	31	8
2012	23	1
2013	19	5
2014	19	5
2015	26	7
2016	26	2





Mum's Account Of Care After Baby Loss 'Should Serve As An Example To Other NHS Hospitals'

***Source NEL Maternity dashboard*)**

Period Q1 2017/18 (April-June 2017)																
North East London Maternity Units	Royal London	Whipps Cross	Newham	BHRUT	Homerton		Royal London	Whipps Cross	Newham	BHRUT	Homerton		Royal London	Whipps Cross	Newham	BHRUT	Homerton
Measure/Indicator	Apr-17						May-17						Jun-17				
Number of deliveries	420	388	524	657	419		434	443	533	701	502		414	387	517	718	521
Number of term intrapartum stillbirths	0	0	1	0	0		0	0	1	0	0		0	0	0	0	0
Number of early neonatal deaths	2	3	3	1	0		4	2	2	1	0		2	3	3	0	0

Key Headlines of our plans to improve Safety; *'Halve it'* Ambition

Implement the ***'care bundle'*** elements	**Smoking Cessation including Public Health and Prevention.**
	Identification and surveillance of fetal growth restriction.
	Reduced fetal movement.
	Effective fetal monitoring across NEL.
Maternal Medicine Network/ Hub and Spoke model	**A model is being developed to improve the care for women requiring specialist care. This will be a managed clinical network with hubs and spokes and with close multi-disciplinary team working in a variety of medical specialities between physicians, midwives, obstetricians and primary care.**
	Cross boundary working: is being developed to improve safety, communication and wider access for high risk women to specialist services.
	Plan for midwives to rotate across all NEL maternity providers. This will be piloted with Band 6s midwives across NEL.
Serious Incidents(SI) and Shared Learning	**Standardisation of clinical guidelines and pathways to reduce clinical variation and improve good practice across the systems.**
	SI learning event to explore how we can improve our investigation reports. Review common pitfalls in SI report writing and will try to find solutions to some of the more tricky issues.
	Adopt bereavement toolkit currently launched by the Clinical Networks to local Trust policies.
	ELLMS involvement with Getting it Right the First Time (GIRFT)

Confirmed trajectory data has been submitted by all providers to reduce rates of stillbirth, neonatal and maternal death

theguardian

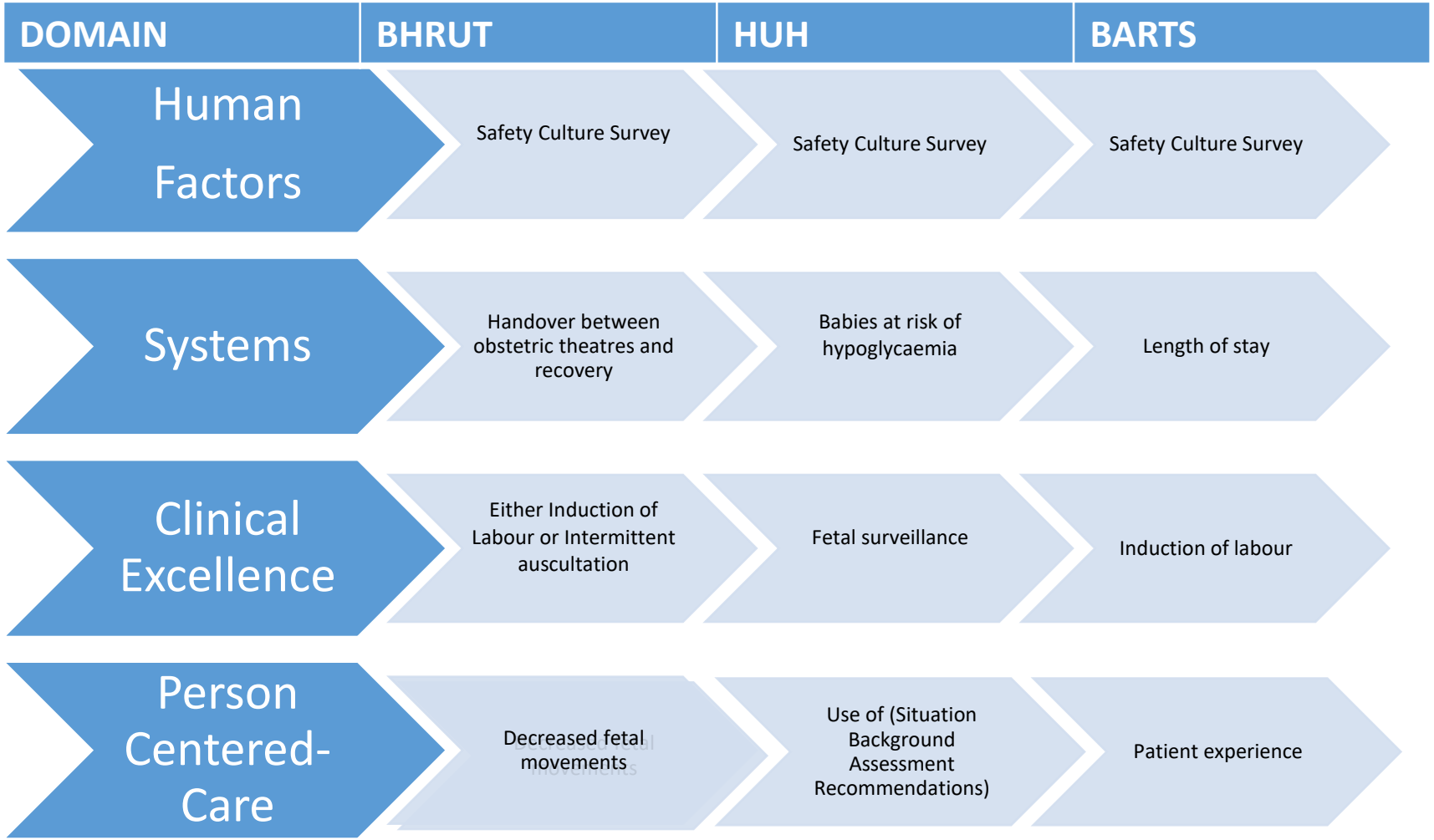
Almost half of maternity wards are turning away mums in labour because they have no spare beds for them

- Units were forced to temporarily close their doors on at least 382 occasions last year
- Hospitals are struggling to cope with the rising number of births and the increasingly complex labours among older and obese women
- Understaffing is compounding the issue, with the NHS currently lacking about 3,500 full-time midwives

North East London maternity units

NEL Indicators																	
Period Q1 2017/18 (April-June 2017)																	
Measure/Indicator	Royal London	Whipps Cross	Newham	BHRUT	Homerton		Royal London	Whipps Cross	Newham	BHRUT	Homerton		Royal London	Whipps Cross	Newham	BHRUT	Homerton
	Apr-17						May-17						Jun-17				
Number of women booking	482	457	637	657	499		314	440	621	701	579		577	513	733	718	563
Number of obstetric labour ward closures per month	0	0	3	0	0		0	0	0	0	0		0	1	0	0	0
Number of obstetric labour ward attempted closures per month	0	0	0	0	0		0	0	0	0	0		0	0	0	0	0
Number of closures and/or suspensions of midwifery led birth settings	0	0	0	0	0		0	0	0	0	0		0	0	0	0	0
Number of term babies with severe brain injury	0	0	1	N/A	0		0	0	1	N/A	1		1	0	1	N/A	0
Number of term intrapartum stillbirths	0	0	1	0	0		0	0	1	0	0		0	0	0	0	0
Number of early neonatal deaths	2	3	3	1	0		4	2	2	1	0		2	3	3	0	0

Key Headlines of our plans : Safety; ‘Halve it’ Ambition - NHS Improvement Maternity and Health Safety Collaborative



Key Headlines of our plans : Personalised Care Planning

- ELLMS have recently launched the Choice Pioneer Programme in NEL to increase and promote choice and personalisation for women. The pilot is being run with a GP practice and with evaluation at the end of 2017 with women receiving detailed information on all providers in NEL and the Choice Midwives to gain insight and learning from the pilot.

- Phase 2 will involve all providers improving the quality and content of discussions around place of birth using resources developed at sector level to improve consistency, quality of information and transparency.

- All providers wish to move current practice of antenatal appointments from 15-20 mins to 30mins as a minimum to allow sufficient time to develop personalised care plans for women. Homerton have already achieved this.

Provider (% and numbers)	Baseline of women receiving a personalised care plan 17/18	Projected numbers for 18/19	Projected numbers for 19/20	Projected numbers for 20/21
BHRUT	0.2% (20 women)	5% (400 women)	10% (800 women)	15%
Homerton	4.38% (250 homebirth women)	10% (600 (homebirth women and obstetric high risk receiving care with obstetrician)	15% (900)	20% (1200)
Whipps Cross	0%	20%	40%	60%
Newham	0%	20%	40%	60%
Royal London Hospital	0%	20%	40%	60%

Definition Better Births : *The development of a personalized care plan by the woman and midwife, built on the decisions each woman makes, and informed by an assessment of the type of care she might need. There must be* ***sufficient time*** *to have this dialogue.*

Key Headlines of our plans : Choice

- All NEL providers have identified that choice of place of birth is made available to women to support them to make decisions about the type of birth and setting of birthing available to them to give birth only within their Trusts. However, the Care Quality Commission (CQC) surveys in 2016 highlighted that most women in NEL expressed that they were **not** offered the choice of where they gave birth.

- The ambition is to expand choice for women across geographical boundaries in line with Better Births.

2017/18	2018/19	3 + years
• Data collection for NEL to develop MyHealthLondon website for women. • Successful bid for additional funding to scale up Choice Pilot. • Audit current choice rates to identify baselines and trajectories.	• Evaluation of Choice Pioneer Programme • Complete the development of information resources (subject to funding) • Implement training to enable midwives to roll out practice widely across NEL This will include “train the trainer’	• Establish commissioning arrangements in line with commissioning guidance and Better Births across NEL to enable choice to be provided widely across geographical boundaries.

Key Headlines of our plans : Continuity of Carer

- No acute provider in NEL currently provides continuity of care in the antenatal, intrapartum and postnatal periods for women other than for very small groups of vulnerable women.
- Neighbourhood Midwives – a pilot midwifery led pilot in Waltham Forest do offer this approach.
- There is an agreement across NEL acute providers to implement a staged approach to continuity of carer at antenatal and postnatal periods at the initial stage before concentrating on intrapartum continuity.

Provider	Current Model of Care (antenatal)	Intrapartum	Post-natal	Proposed Model of Care
BHRUT	Continuity of care begins at time of booking	Partially to specific high risk groups	Partially	**Caseloading team**; named midwife will provide care from early in pregnancy i.e. booking through labour and birth, up to two weeks postnatally.(if woman still resides locally).
Homerton	Continuity of care begins at time of booking	Partially to specific high risk groups	Partially	**Caseloading team**; named midwife will provide care from early in pregnancy i.e. booking through labour and birth, up to two weeks postnatally.(if woman still resides locally)
Whipps Cross	Continuity of care begins at 16 weeks	Partially to specific high risk groups	Partially	**Midwifery Group Practice Caseload care**: Women will be booked by a named midwife who will see them for majority of their antenatal, intrapartum and postnatal care.
Newham	Continuity of care begins at 16 weeks	Partially to specific high risk groups	Partially	**Midwifery Group Practice Caseload care**: Women will be booked by a named midwife who will see them for majority of their antenatal, intrapartum and postnatal care.
Royal London Hospital	Continuity of care begins at 24 weeks	Partially to specific high risk groups	Partially	**Caseloading team**: initially will be led by the home birth team focusing on the Barkantine Birth Centre; named midwife will provide care from early in pregnancy i.e. booking through labour and birth, up to two weeks postnatally.(if woman still resides locally)

Proposed trajectories: Continuity of Carer

Provider	Current year (2017/18)	Y1 (2018/19)	Y2 (2019/20)	Y3 (2020/21)
BHRUT	0.2% (20 women)	5% (400 women)	10% (800 women)	15%
Homerton	4.38% (250)	5% (300)	7.5% (425)	10% (600)
Whipps Cross	0.1%	0.5%	3%	6%
Newham	2%	3%	5%	10%
Royal London Hospital	0.1%	3%	5%	10%
Neighbourhood Midwives	100%	100%	100%	100%

The proposed trajectories are significantly dependent on funding

Engagement with women and other stakeholders

- As an essential part of shared learning and stakeholder engagement the ELLMS has engaged with approximately 502 local women and their families in 2017 across a number of forums, events and meetings to involve, inform, co-produce and co-design a number of these plans.
- Other key stakeholders have also been involved and a log of engagement is maintained for evidence.

Women's Experience in NEL

Why was choice important to you?

Comment 1

"Choice is incredibly important in the process of preparing to give birth and can have a huge impact on the mental state a mother experiences as her due date approaches. For me, to know that I could have my baby at home meant that I could visualize the event and plan everything to help make it a reality. This ensured I was calm and positive as my pregnancy progressed - qualities that are vital to a healthy pregnancy and complication-free birth".

Comment 2

"I would not choose a home birth…In my opinion, home birth is dangerous".

Comment 3

"Having a choice was particularly important to me because the idea of having a hospital birth really did not appeal".

Comment 4

"Hospital should be primary place of childbirth not home".

Would you like to see the same midwife and doctor throughout your maternity care?

Comment 5:

"*It depends on the individual"*

Comment 6

*"I was really pleased to be accepted onto the NHM pilot as it meant that I would see the same midwife the whole time, and they would be my midwife at the birth. My midwife was *** and I cannot speak highly enough of the care I received from her. It really makes such a difference getting to know the person who will assist you during what is a very personal experience".*

Key Headlines of our plans : Co-designing with local women

2017/18

- ❑ Agree with WEL commissioners x3 on the terms of agreement and functions of their MVPs – this will include how CCGs wish to use MVPs to influence commissioning and improve maternity services
- ❑ Completion of MVP mapping process for NEL including sign off from Chairs to send to the regional team.
- ❑ Baseline mapping of information provided across the NEL to develop centralised resources and consistency of information provision.
- ❑ Providers will regularly gather and collate information on women's experience to analyse it and feedback results to the maternity management team in order to support and inform service improvement.

2018/19

- ❑ Commission the 3rd sector to carry out needs based analysis with a wider number of local women in NEL.
- ❑ Development of new websites and social media forums.
- ❑ Recruit local women on LMS.
- ❑ Hold women's experience workshops across the STP to ensure women are informed of the LMS plans and progress and receive feedback.
- ❑ Develop briefing room on STP website with maternity delivery plans, updates, useful publications and information on services for local women.

3 + years

- ❑ Active participation across NEL from local women with CQC surveys.
- ❑ Improve methods in which information is disseminated to women specifically in relation to safety by translating information to more languages given the diverse population of NEL.

Key Headlines of our plans : Procurement

- In line with Lord Carter's review of efficiency in hospitals and the recommendations made on how large savings can be made by the NHS by reducing unwarranted variation in productivity and efficiency to make cost savings by 2020/21, the LMS have agreed to participate with the STP on a joint provider collaborative to centralise back office functions. Procurement is one of the workstreams which the LMS has agreed to undertake collaboratively.

- A gap analysis has been carried out and it has been identified that there is a variation of products between the 5 provider sites and some waste has been identified as well as a variety of pricing.

- The LMS is represented by the SRO on the STP Procurement Working Group and has BHRUT as the host. The process is currently being piloted and certain consumables, delivery packs and suture packs are being identified to be procured centrally as phase 1.

- Approximately £60,000 savings identified on delivery packs.

2017/18

- **Phase 1-** Initial scoping meetings to be held with NHS Supply Chain Buyer and the STP to agree collaborative approach and agree items to jointly procure.
- Identified provider leads to lead project.
- Market overview analysis.
- Agree standard delivery pack for costing and submission of volumes.

2018/19

- Pack buyer review of milestones
- **Phase 2** – agreement of additional items which can be procured jointly.

3 + years

- Cost savings realisation benefits to be carried out to evaluate provider efficiency at STP level.

NEL Maternity Workforce Challenges

- There are substantial workforce challenges given that 4% of the maternity workforce are in the retirement age cohort and the national trend of lack of middle grade obstetric staff will have an impact. By definition safe service delivery can only be achieved with safe staffing levels and therefore workforce recruitment and retention will remain a top priority.

- It is likely that there will be a potential recruitment implications for midwives based on impact of Brexit. 40% of the workforce is EU/non UK and 44%, is non-EU.

- 4% of the NEL maternity workforce could potentially leave service due to retirement in the 8-5 years and a further 12% of the workforce are within the ages of 55-60 and therefore in the cohort approaching retirement within the next 10-15 years.

(Data source: Health Education England)

More nurses and midwives leaving UK profession than joining, figures reveal

3 Jul 2017

Midwife shortages blamed for home births falling to 15-year low

16 Oct 2017

Midwife shortage makes women in labour feel like 'cattle', says report

Key Headlines of our plans : Workforce

- Supporting transformation of the workforce is complex and vital to success.
- Known national challenges in numbers of middle grade trainee obstetricians and ultrasonographers.
- Recruitment and retention in NE London has been difficult to achieve.
- Plan finalised and implementation to commence in Q4.

Develop an innovative recruitment network which provides an opportunity for midwives to rotate across all NEL providers.

Encourage people to remain in NEL i.e to live and work working closely with communications and engagement teams.

Improve work life balance and staff satisfaction.

Support staff to develop new models of care with a high degree of autonomy.

Consideration for a review on the benefits of standardizing inner/outer London weighting for Band 6s midwives as an initial pilot.

Invest in staff training and development.

Key Headlines of our plans : Digital

- Agreed across the sector that there is a need to develop an integrated IT and digital system across NEL to transform and support the provision of modern maternity care.

- Better Births, outlines that NHS providers should invest in technological solutions that observe the following principles:

✓ Women, families and professionals should be able to access it, with the appropriate permissions from the woman.

✓ It should be accessible via a mobile device so that midwives can use it at booking and that it is accessible in community hubs and at home.

✓ It should be accessible by staff at the community hub and hospital services, and connect with hospital records systems.

✓ It should be accessible by all providers of maternity and maternity-related care within the local maternity system.

This is considered to be one of our key enablers for the entire transformation agenda

Key Headlines of our plans : Digital

201718

- Map current digital positions with each provider through the digital STP workstream to identify plans and funding gaps to deliver transformation.
- Map hardware and infrastructure require requirements across all Providers.
- Identify software changes required to support community data requirements.
- Develop project plans per site with support from STP digital leads to capture operational site and STP wide requirements.

2018/19

- Implement NHS Digital tool to improve/facilitate digital access to maternity records for women.
- Purchase mobile devices / capital infrastructure for community midwives with in-built clinical applications.
- Review current IT infrastructure in the community and requirements. Align with ELHCP Digital Plan.
- Develop specification for interoperability across community and acute services.

3 + years

- Implement digital interoperability across provider sites including community and acute.
- Ensure clinical applications are designed and developed to measure care models e.g. continuity of care across provider sites.
- Shift to a paperless care model.

Key Headlines of our plans : Estates

- The NHS needs to organise its services around women and families. Community hubs should be identified to help every woman access the services she needs, with obstetric units providing care if she needs more specialised services. Hubs, hospitals and other services will need to work together to wrap the care around each woman.

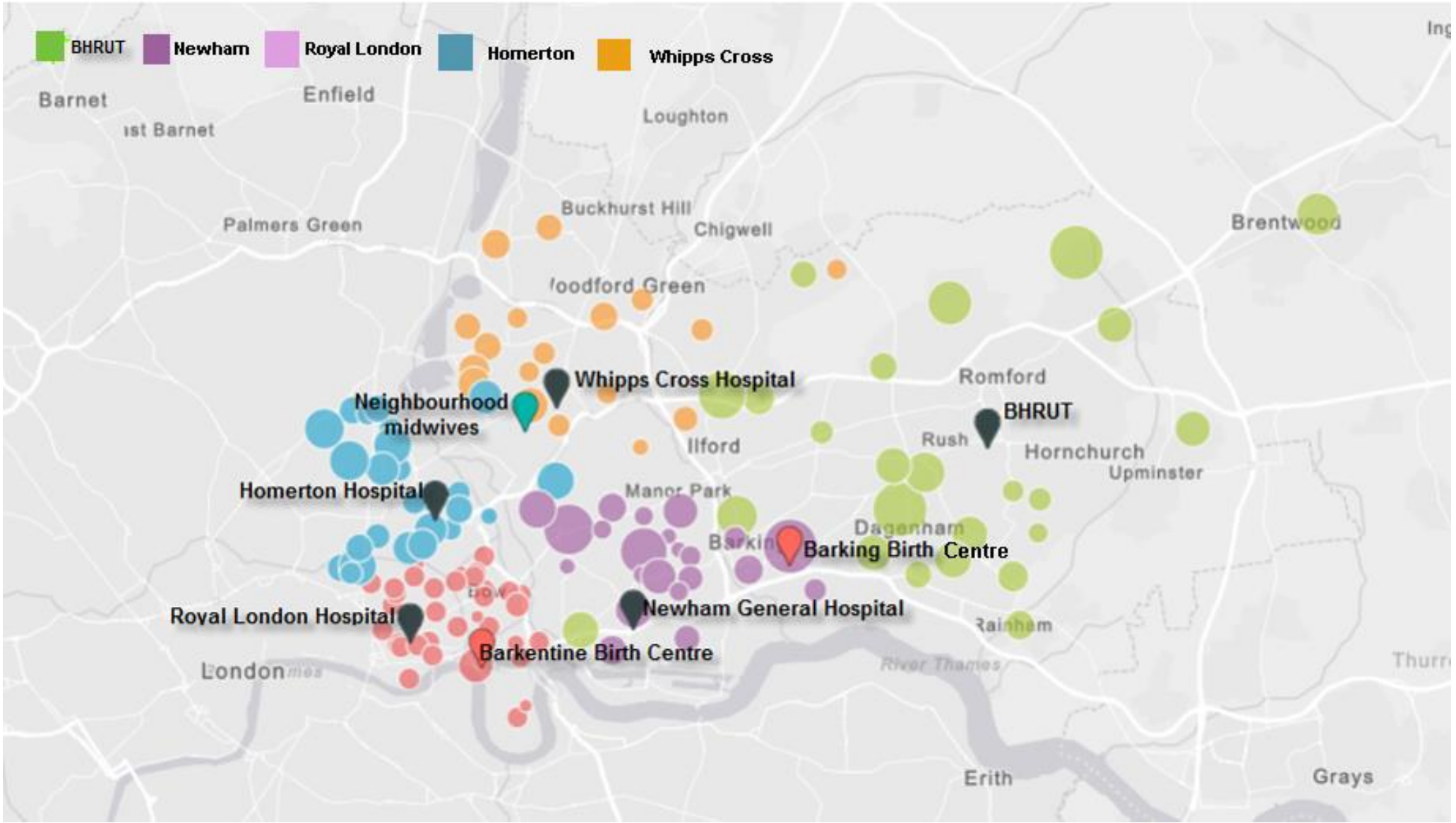
- A community hub is a local centre where women can access various elements of their maternity care. They could be located in a children's centre, or in a freestanding midwifery unit or embedded in new at-scale models of primary care, including multispecialty community provider models being adopted by many GPs as part of the NHS Five Year Forward View implementation.

- Different providers of care can work from a community hub, offering midwifery, obstetric and other services easily accessible for women. These might be ultrasound services, smoking cessation services or voluntary services providing peer support.

- Key issues is affordability which has been escalated to STP, regional and national Maternity Transformation Boards.

Estates - Current Community Provision

Current provision in some areas is primarily in small clinics in GP surgeries which offers some opportunities for joined up working but often poor connectivity, flexibility and choice for women.



Key Headlines of our plans : Perinatal Mental Health

- North East London providers have collaborated on perinatal mental health bid for transformation funding.
- The LMS supports and endorses this bid.

Recruitment and training of specialist staff to enable us to increase the numbers of women accessing PMHS.

Co-production with women and families to ensure PMHS meets patient needs and improves patient experience.

Implementation of shared outcomes and targets e.g. waiting times and recovery rates.

Development of shared pathways and policies across NEL e.g. treatment approaches and criteria and thresholds for care.

Design and delivery of a NEL wide perinatal mental health training strategy.

Strengthened stakeholder engagement and integration, including with all STP maternity, community adult and inpatient mental health and primary care and voluntary sector providers.

Key Headlines of our plans : Neonatal Services

- In September 2017, the Local Maternity Systems received an announcement from the **London Neonatal Operational Delivery Network** outlining **Integrating Neonatal Care into Local Maternity System Transformation Plans.**

- The expectation of NHS England that Neonatal ODNs influence Local Maternity Transformation plans and retain responsibility for the neonatal content planning and delivery.

- Neonatal ODNs will support their Local Maternity Systems and co-develop an overarching regional strategy to deliver improvements in the following areas;
  - ✓ Optimisation of birthplace for premature infants to support the national ambition
  - ✓ Reduction in term admissions (ATAIN programme)
  - ✓ Workforce Planning
- NEL are awaiting information from the neonatal ODN for NCEL to support the integrated working between the services.

Key Headlines of our plans : Innovation & New Care Models

- Piloting a new model of care with a new provider Neighbourhood Midwives.

- In a position to pilot new models of tariff and new ways of cross boundary working with the new provider.

- Supporting and engaging with innovative research such as ‘REACH’ which is researching radically different model of group antenatal care with large numbers of women and peer research with some of the most vulnerable women using our services.

- Working to develop new models of transitional care, including developing care in the community that would currently be hospital based.
- Health Innovation Grant (£75k)for a new antenatal education model which will include co-production and evaluation.

Maternity Transformation Bid Proposal

Provider	Revenue 2018/19	Recurrent revenue 2019/20	Sum of Non recurrent revenue 2020/21	Capital 2018/19	Capital 2019/20	Total for all years excl over heads	Overheads	Grand Total
BHRUT	501,672	471,062	480,644	477,000		1,930,378	71,519	2,001,897
HUE	542,538	553,388	564,456	7,000		1,667,382	83,369	1,750,751
NUH	330,467	414,676	424,970	83,000		1,253,113	62,656	1,315,769
WXH	310,467	317,676	325,060	84,000		1,037,203	51,860	1,089,063
RLH	244,911	249,809	254,805	153,000		902,525	45,126	947,651
STP	184,001	187,691	191,456			563,148	28,157	591,306
Grand Total	**2,114,056**	**2,194,303**	**2,241,390**	**804,000**		**7,353,750**	**342,687**	**7,696,437**

NEL has recently submitted a bid proposal to NHS England for investment to support the delivery of maternity transformation.

Potential savings opportunities will include:

- ❑ Moving more births to midwifery led units.
- ❑ Centralising and standardising our procurement arrangements across NEL.
- ❑ Reduction in litigation costs as a result of improving safety in maternity services and engagement from GIRFT.

Key Risks

- **Organisational Changes -** With the formation of accountable care systems in NEL, there will be considerable staff changes specifically at senior level across organisations.
- **Funding -** With no significant investment and being faced with a STP financial gap across the footprint, if funding is not made available, it will be almost impossible to implement Better Births.
- **Demand and Capacity -** If the response to the current and future demand for maternity services is not met urgently, there is a potential risk that women will experience unsafe, poor quality services which do not meet their needs or choices.
- **Digital and Data Quality -** The pace of estate, digital and workforce enabler responses are insufficient and impede the necessary step change required to manage maternity service demand.
- **Workforce -** the system's workforce challenges could impact on the quality, scale, safety and delivery of maternity services in NEL.
- **Time and Capacity -** Provider time and resource to deliver the NEL LMS plans effectively, at scale and on target.
- **Continuity of Care -** The delivery of continuity of care in line with the FYFV is dependent on the professional and personal capabilities of the maternity workforce.
- **Estates -** Due to recent lease regulations from NHS Properties, providers are facing the challenge of developing community hubs due to the cost of estates.
- **Governance** – Neither the STP nor the Local Maternity System are accountable for delivery of maternity systems. NHSE has outlined a governance framework for the KLOEs to be monitored via these non-statutory bodies.

Some of our successes…

- An established caseloading team at Barking Havering and Redbridge University Hospitals, NHS Trust
- The development of the Neighbourhood Midwives Service in Waltham Forest.
- NEL is one of the 7 footprints in the country to be involved in the Pioneer Programme.
- An established cardiology maternal medicine network model across NEL.
- Centralised some maternity procurement arrangements for NEL.
- Well-established links and referral flows across maternity services and good working relationships in NEL.
- Barts Health is one of UK's largest Trusts with 5 centres offering broad range of sub-specialties – critical mass, state-of-the-art clinical infrastructure, research, education and training.
- A number of established models of care (in NEL) cited in the Better Births Review as best practice including authorship from one of our local GPs.
- Recent appointment of a consultant midwife at the Homerton to be the Co-Clinical Director for the London Maternity Clinical Network.
- Providers in NEL have won several national awards acknowledging their efforts to implement positive outcomes for women and Better Births.
- Strong ELLMS leadership and collaboration.

Inner North East London (INEL) **Joint Health Overview and Scrutiny Committee** 9th November 2017 **North East London Sustainability and Transformation Plan; Mental Health**	Item No **5**

OUTLINE

Over the course of 2017, health and care organisations across 7 boroughs in North East London (NEL) have been working to develop a draft Sustainability and Transformation Plan (STP). The STP sets out how the NHS Five Year Forward View will be delivered across the NEL footprint and how local health and care services will need to transform in order to ensure their financial sustainability and improve their clinical effectiveness.

INEL JHOSC has requested that NHS partners provide an overview of how the draft NEL STP will be developed through consultation, engagement and scrutiny processes so that the plans are given appropriate oversight and accountability.

This report provides overview of the activity being undertaken through East London Health & Care Partnership with regards to workforce. In particular, it provides assurance around the activities being undertaken to address recruitment and retention challenges; and the progress made in transforming the out of hospital workforce.

ACTION

- The Committee is requested to give consideration to the report and discussion and provide comments.

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East London Health & Care Partnership

East London Health & Care Partnership Sustainability and Transformation Plan (STP)

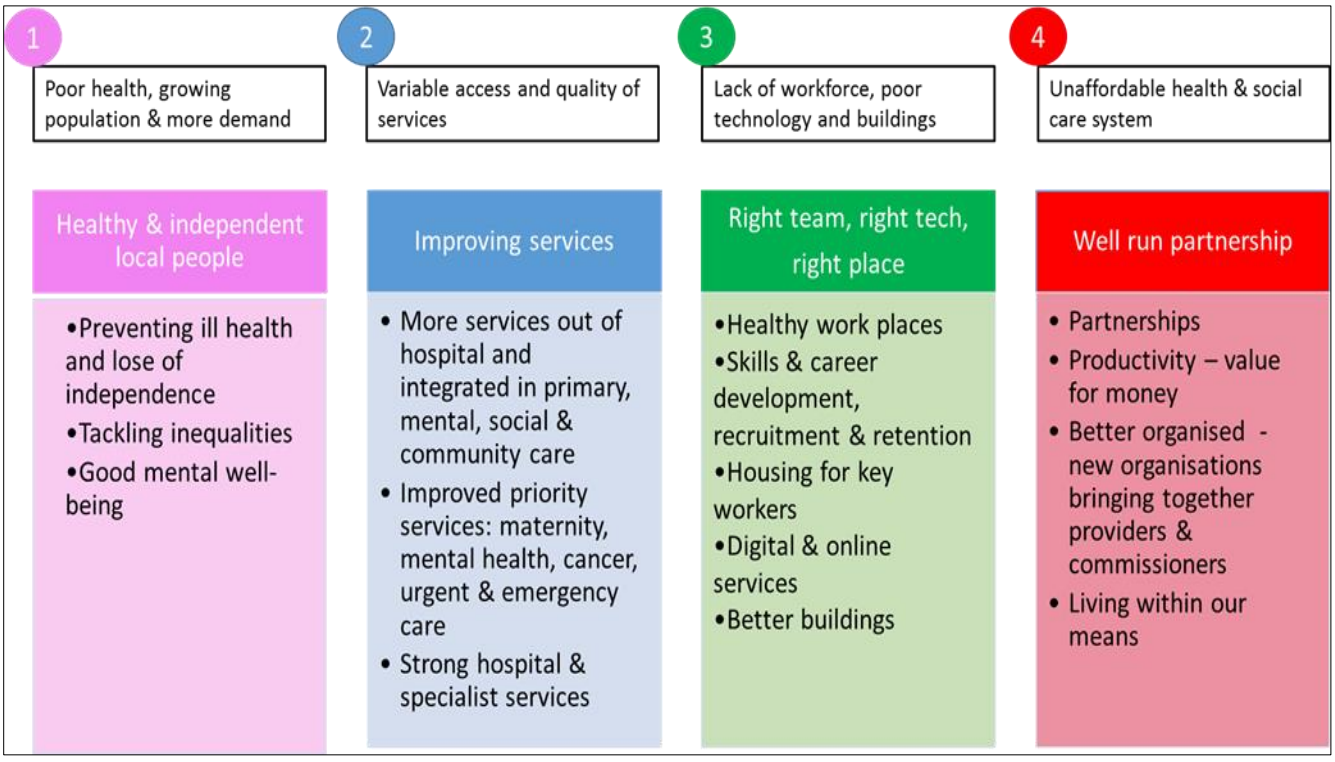
Date of Meeting: 9th November 2017
Meeting Title: Inner North East London Joint Health Overview and Scrutiny Committee
Authors: James Cain, Head of Workforce Transformation, Health Education England
Presenter(s): Tracey Fletcher, Chief Executive Officer, Homerton University Hospital NHS Foundation Trust James Cain, Head of Workforce Transformation, Health Education England Dr Sanjiv Ahluwalia, Postgraduate Dean, Health Education England
Purpose: The purpose of this paper is to provide the Inner North East London Joint Health Overview and Scrutiny Committee with an overview of the activity being undertaken through ELHCP with regards to workforce. In particular, it provides assurance around the activities being undertaken to address recruitment and retention challenges; and the progress we are making in transforming the out of hospital workforce.
Background Given the anticipated growth in our local population, we will have varying gaps between supply and demand of professional groups between now and 2020. Demand for nurses reported by our providers currently exceeds supply (e.g. staff in post) and these issues are exacerbated by the Government changes to funding for the non-medical workforce. We can also expect a surge of ST3-ST8 trainees completing their training; and these staff are currently aligned to hospital settings. GP training posts have increased; but the current supply pipeline is not in keeping with the demand increases expected across North East London (NEL). There are plans to re-profile GP training locations across London to bring more activity into East London; thus ensuring better equity of GPs across London's 32 boroughs. In order to address the challenges in NEL; Health Education England continues to invest in growing the non-medical workforce and in 2017 is introducing 42 more practice nurse trainees; 124 nursing associate trainees and 15 medical assistant trainees. HEE is also increasing the trainer capacity across NEL to absorb a further increase in GP trainees. In order that we address the nursing pressures we have across London; a number of activities are being undertaken. Firstly, we are focusing our HR and Nurse Directors on the retention of our nursing workforce; and each provider has set out ambitious plans to retain a greater number of nurses who would otherwise leave NEL or indeed health and care overall. We are committed to the ambition of the London-wide CapitalNurse programme and have already commenced 194 acute and community rotations. We are also looking at how we can create an NEL-wide set of specific CapitalNurse priorities; developed by

the Directors of Nursing at Barts Health NHS Trust and East London NHS Foundation Trust. Barts Health are leading the NEL-wide Nursing Associate programme and we can expect this new type of worker to enter our workforce shortly. Critical to the sustainability of our health and care workforce moving forward is a NEL-wide approach to apprenticeships; so that we can attract local people to local jobs whilst maximising on our local contributions to HMRC through the apprenticeship levy.

We also have a clear set of overarching educational outcomes aligned to HEE's mandate; and we are working with UCLPartners on programmes around: Leadership; Palliative Care; Mental Health; Digital; Integration; Carers; and the development of sustainable educational faculty.

We have formed a Local Workforce Action Board which oversees our ambitious workforce programme; and supports our response to national strategies such as the General Practice Forward View; the General Practice Nursing 10 Point Plan; and the national mental health workforce strategy. Where required; each of these programmes also links with the core STP programmes: e.g. the primary care programme and the mental health programme.

ELHCP's Four Core Priorities



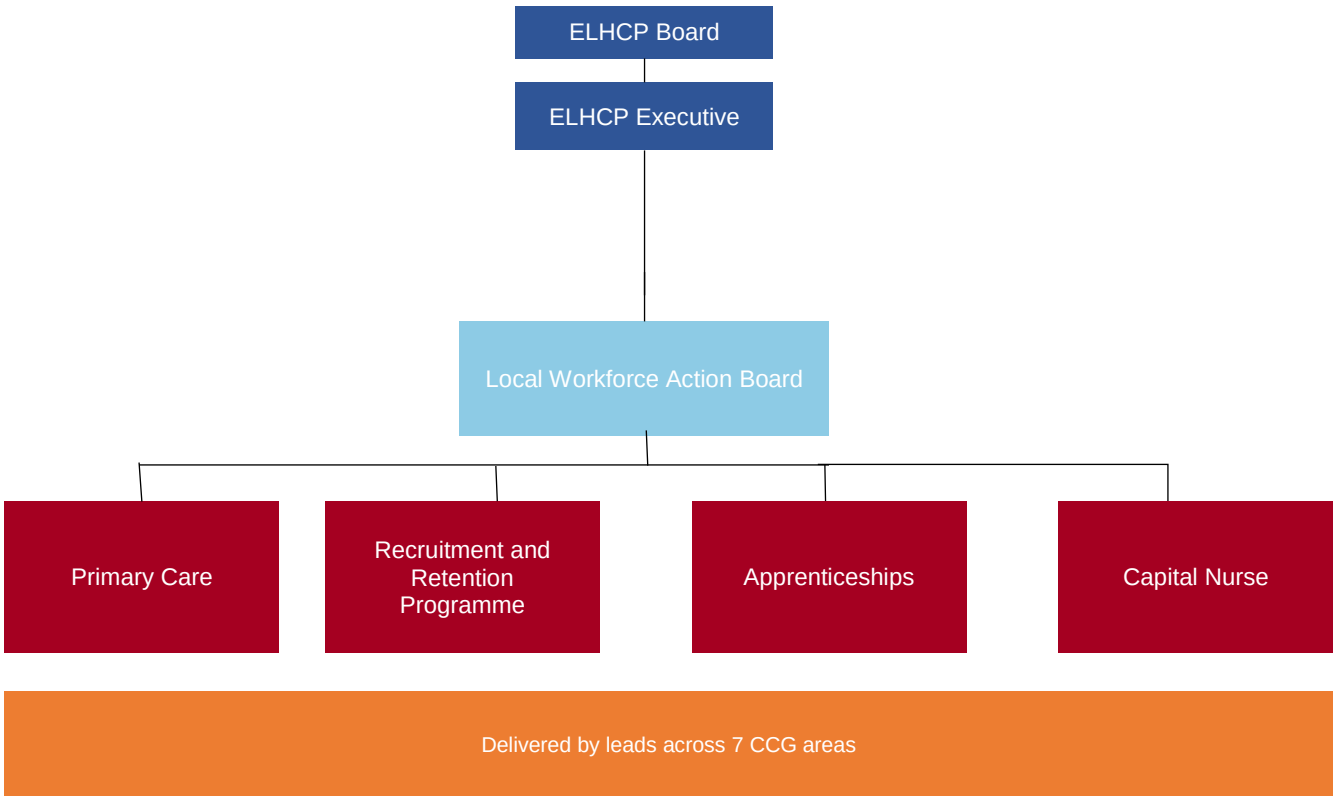
1. Case for Change

The key points surrounding our case for change are as follows:

1) 26% of Nurses across London between 2011-2016 left the NHS; with similar trends for other professions
2) The Comprehensive Spending Review removed funding for non-medical education and training; reducing our control of the education pipeline for these staff
3) Vacancy and turnover rates for Nursing and AHPs is too high - e.g. a 16% vacancy rate for Children's Nurses and a 14% turnover rate.

4) We are producing more hospital based doctors than we need in some specialties and have a surge of ST3-ST8 trainees who will shortly be leaving training and applying for CCTs.
5) There are 35,000 jobs in social care; of which 25,000 provide direct care and 1,700 are regulated professions such as nurses. Vacancy rates across both types of role are akin to those of the NHS.
6) Waltham Forest has the third oldest GP workforce in London; with only Barking and Dagenham and Havering ahead of it. Newham is in the upper quartile for age; whilst Tower Hamlets and Newham have a younger workforce. Retirement is therefore a greater issue in some of our boroughs than others.
7) GP training numbers across INEL have increased over the past 3 years; but more GPs are still needed. There are discrepancies between data recorded through NHS Digital and actual training pipeline data.
8) In 2014; 50% of GP trainees in London remained in the area they trained in; where 85% stayed in London overall.
9) ONS data for the whole of NEL suggests that NEL will see a higher population growth than any other STP footprint in London.
10) Indices of Multiple Deprivation suggests that INEL boroughs are amongst the most deprived in London; suggesting a greater disease burden.

Governance



2. Delivery Plan

- Retention Programmes at Trust level – All on target
- ELHCP Level retention programmes – Slipped due to absence of HR Lead; now being recruited to
- Support of clinical work-streams – In progress, behind schedule. Expected to accelerate with additional team resources coming into place to support this work.
- Apprenticeships Programme – All on target
- 2017/18 investment programmes – All on target
- CEPN Programmes - All on target

- Primary Care Workforce Model – All on target

3, Difference to local people

Also outline any core engagement activities if appropriate e.g. Residents, Patients and Public, Carers, Staff, EHLCP briefing room, service user engagement, workshops community groups, etc.)

We have undertaken, with the support of the ELHCP Director of Communications and the Transforming Services Together workforce programme, to develop a brand around East London as a career destination of choice, which promotes the exciting opportunities we provide to our staff. We have also mapped out the opportunities for apprenticeships across our providers, which provide opportunities for local people to embark on exciting career pathways across our footprint. We intend to build on the schools' outreach programme developed by Barts Health and develop greater awareness of careers in care through our care ambassador programme.

Ultimately, everything we do around workforce across ELHCP has the ambition of ensuring we have the right workforce, with the right skills and values, in the right place, at the right time. Our focus is on ensuring we can provide excellent care closer to home, supported by the right hospital workforce for those who need to use our hospital services.

4. Financial Information

The STP financial template submitted to NHS England in October 2016 demonstrates a do nothing total expenditure of £2,009,154k for substantive and bank workforce in 2020/21 and agency expenditure of £189,488k. The financial plan indicates a planned reduction in 2020/21 of £143,331k for substantive and bank and £19,737k reduction in agency usage.

There are a number of initiatives planned at provider, ELHCP and London level to reduce the amount of money we spend on agency staff through agreeing new capped rates and break glass protocols. We plan to increase the attractiveness of permanent/bank employment through reviewing how we roster our staff, the opportunities for part-time work; and opportunities for rotational work across ELHCP. One of our biggest efficiencies can be delivered through retaining staff for longer and this has been modelled into the financials. Savings relate to lower recruitment costs; a higher number of permanent workers; and less delays in 'time to hire' all have a positive financial impact.

Many of the investments needed to realise these improvements (e.g. retention, supply and training) have been sourced from Health Education England. Other improvements need to be realised through exploring alternative clinical/non-clinical skill mixes to deliver efficient services.

5. Outline support required from the Inner North East London Joint Health Overview and Scrutiny Committee.

ELHCP would welcome the views of the INEL JHOSC on the activities we are undertaking across our footprint pertaining to workforce. We would be particularly keen to have a discussion around the five key questions at the end of the presentation.

Key to the success of this programme is radically improving the retention of our workforce. Much of this is within our control as employers (training, terms and conditions, workplace wellbeing etc.) but we would welcome support on wider socio-economic impacts such as affordable housing.

Recommendations:

The Inner North East London Joint Health Overview and Scrutiny Committee is requested to:

- Comment on the activity being undertaken across ELHCP
- Debate the questions set out at the end of this presentation
- Comment on how we can collectively address socio-economic challenges such as affordable housing

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East London Health & Care Partnership

Workforce strategy discussion

INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

9 NOVEMBER 2017

Introduction

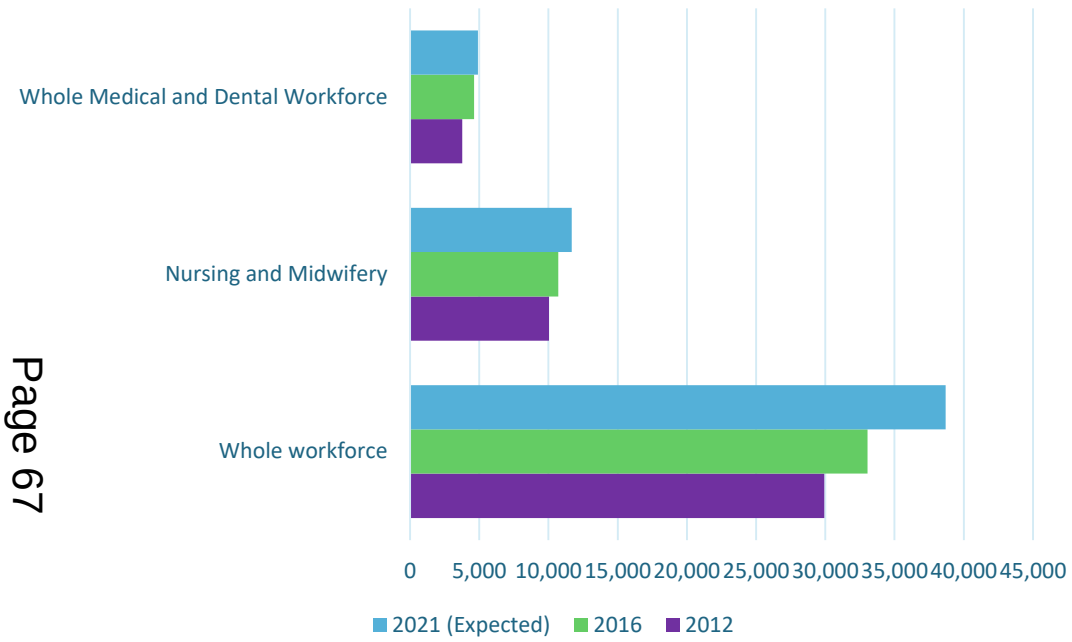
Health Education England (HEE) established a Local Workforce Action Boards (LWAB) for ELHCP to coordinate and support the workforce requirements of the STP.

Functions:

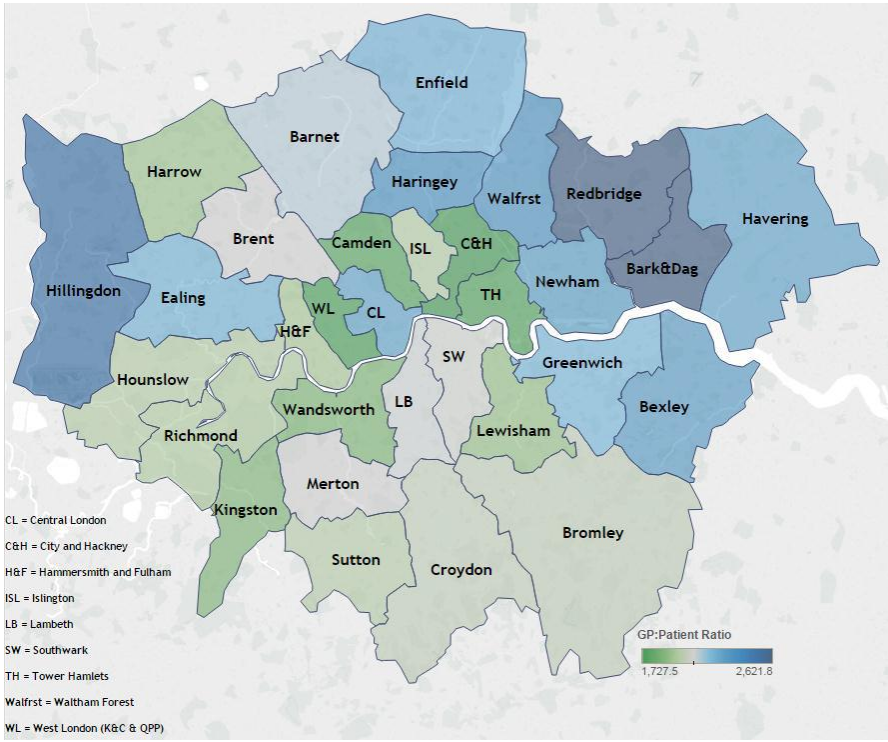
- Each LWAB is co-chaired by a CEO from within the STP and a senior HEE local office leader
- Membership is drawn from health and social care organisations within the STP; as well as education providers, unions and others
- LWABs act as delivery groups alongside other relevant enabling functions within the STP governance arrangements
- LWABs are able to access workforce transformation resources from HEE, as well as any local financial and other support available from stakeholders
- LWABs support the local system to respond to its workforce challenges; and also have responsibility for delivering aspects of HEE's Government mandate.
- Some functions remain with HEE's Local Education and Training Board for London and the South East.
- LWABs have a core programme activity and will act as an enabler (receiving and debating) the workforce aspects of key clinical themes. Such issues must be surfaced by stakeholders involved in each programme.

The ELHCP Workforce – a snapshot of our supply

ELHCP Secondary Care Supply Predictions (do nothing)



London-wide GP to Patient ratios

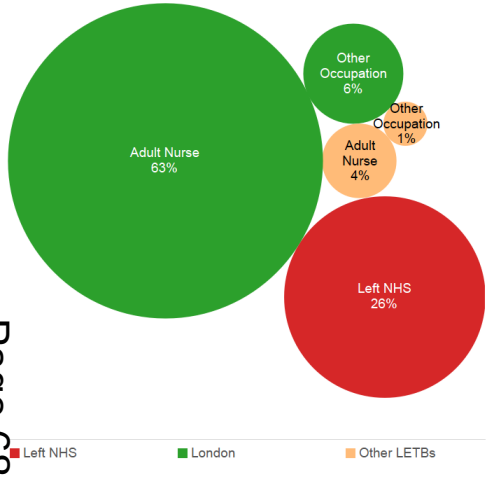


ELHCP social care current workforce composition

	All job roles	Job groups			
		Managerial	Regulated profession	Direct Care	Other
ELHCP Total	35,000	3,400	1,700	25,000	3,800

Summary of *some* of the issues we face

26% of adult nurses employed in the NHS in 2011 had left by 2016



Vacancy and turnover rates are high

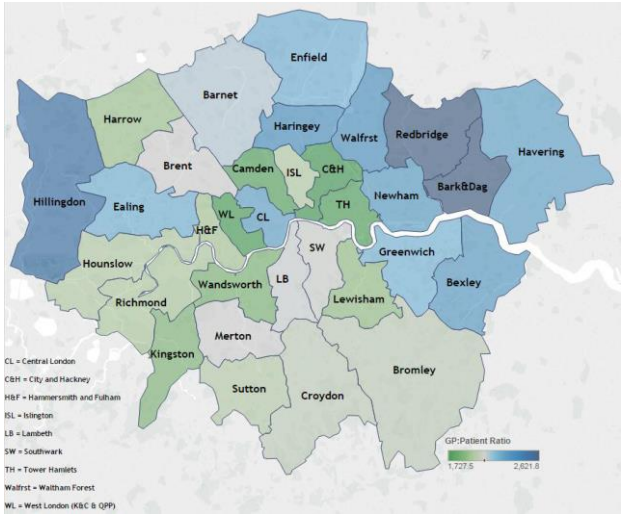
Nursing strand	Vacancy rate	Turnover rate
ELHCP footprint		
Adult Nursing	11%	14%
Child Nursing	16%	14%
Learning disabilities Nursing	15%	13%
Mental Health Nursing	7%	10%
Midwifery	5%	10%
School Nursing	19%	20%
District Nursing	22%	15%
Health Visitors	13%	13%

Our confidence in future supply has significantly reduced

theguardian

Nursing degree applications slump after NHS bursaries abolished

The GP:Patient ratios for aspects of ELHCP are amongst the most challenged in London and England



At the same time, ELHCP boroughs will see some of the highest population growth by 2020

Deprivation across our footprint is high

Workforce Programme activity to date

1) Recruitment and retention – supported by a £1.35m HEE grant across five provider trusts
   i) Employer level interventions – e.g. on-boarding, leadership, mentoring, health and wellbeing
   ii) System level interventions
      a) Review of why people leave (and stay) to inform system level response
      b) Apprenticeships strategy
      c) Bank and Agency – through productivity group

2) Primary care model for the future and enabler programme – to be supported by a £900K HEE grant

3) CEPN Transformation Programme - supported by a £1.25m HEE grant across five provider trusts

4) Person Centred Care Education Framework implemented across five provider trusts – supported by a £325k HEE grant

3) New Role Development – including funding for MAs, PAs, NAs etc.

4) Responding to the non-medical workforce outcomes of the Comprehensive Spending Review with our HEIs

5) HEE/UCLP joint transformation programmes

6) Engagement with clinical work-streams

Recruitment and Retention Programme

East London Health & Care Partnership

ELFT	NELFT	HUHFT	BHRUT	BARTS
Developing further research on ELFT year one leavers	Review recruitment, selection and on-boarding processes	Appointment of nurse to lead on developing nursing recruitment and retention initiatives.	Nurse/midwife within the recruitment team to support the delivery of two year recruitment and retention plan	Marketing and celebrating Barts as an Employer of Choice
Retention of older workers without Mental Health Officer Status	Accelerate the embedding of QI methodologies	Funding of additional training programmes to support nurse career development.	Enhance the on-boarding experience of staff	New Role, Career Pathways and education frameworks
Retention of newly qualified nurses	Implement an e-Learning programme for the prevention of bullying harassment and abuse.	Establishing a mentoring and development programme for talented staff and high performers.	To fully utilise the use of social media and internet applications to improve recruitment and retention	Career Service Development
Increasing retention of staff through investment in joy in work	Implement an assessment and development and mentoring programme for new managers	Establishing a comprehensive induction and mentoring programme for new managers.	Development of an attraction strategy and initiatives offered	Retention of current staff
Structured supervision and development programme for bank staff to move into substantive posts.	Contribute to an STP wide analysis of leaver data	Targeted organisational development support for teams and identified through the staff survey.	The implementation of assessment centres for Consultant Appointments	Training and Development Opportunities
	Implement a programme of stress awareness and mental well-being support	Development of a staff recognition strategy and programme		Focus on our flexible workforce
		Mental well-being support programme for staff		
		Retention of current staff in NEL		
		Training and Development Opportunities		
		Flexible workforce focus		

Recruitment
Retention
Training & Development
Research

And at an ELHCP Level -

1) Understanding the reasons why people leave/stay to inform future initiatives
2) Streamlining our approach to talent management
3) Development of an ELHCP Apprenticeships strategy – to respond to the 0.5% HMRC Levy and the 2.3% Public Sector Target

Primary Care Workforce Modelling Programme

East London Health & Care Partnership

Developing future workforce profiles at an ELHCP and WEL/CH/BHR level, thus informing our requirements around supply of new and existing roles in the future

Workforce modelling tool which engages GP Leaders across each sector

Workforce information

This CCG and STP level workforce calculator is designed to provide a guide to the numbers of staff required in primary care over the next 5 years.

Select NEL STP followed by the CCG / Region you are interested in.

All cells in orange are inputs to the calculator and can be adjusted to represent the local ways of working in the selected CCG.

STP area: NEL

CCG: City & Hackney

Current Proportional split of contacts between staff types

GP	63%
Nurse	13%
Other	12%

Consultations per person per year	5.50
% growth in consultations per person per year	2.38%
Total primary care consultations 2016	1,729,734
Total primary care consultations 2021	2,298,783

Update / Calculate Sheet

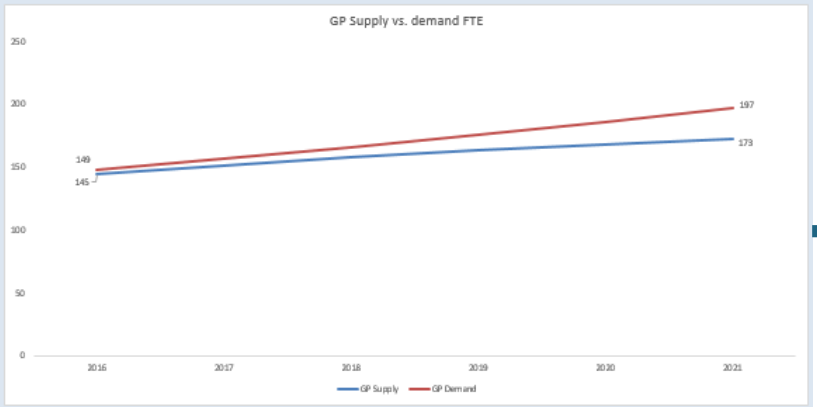
GP information

GP appointment information

	Proportion	Time (mins)
Face to Face	78.5%	10
Telephone	14.5%	7.5
Online Consultation	5.0%	15
Group Consultation	0.5%	12
Home Visit	0.5%	45

Average GP Appointment Time (mins): 10.073

Percentage non-patient facing time	30%
Percentage over 55 GPs retiring per year	15%
Percentage staff leaving for other reasons	3%
NQ GPs joining per year FTE (assumes 70% of ST3 trainees remain in CCG)	13.3
New joiners per year FTE (Excluding NQ)	11.4
Average Hours worked per day	8
Average number of days worked per year	221



Potential Workforce Profiles

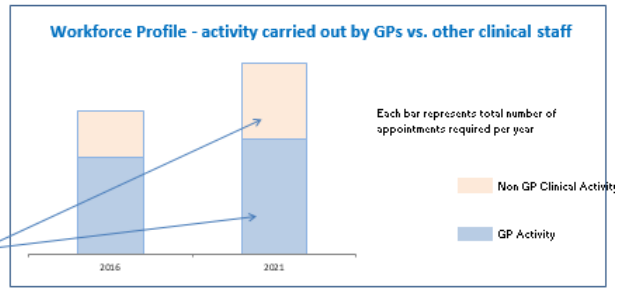
Please select the sample population size to obtain more granular level detail of workforce profiles.

Sample 2016 Population Size: 80,000

Sample 2021 Populatio: 31,800

2021 GP Activity: 60.3%

	All Borough		Sample Population	
	2016	2021	2016	2021
Population	314,497	360,887	80,000	31,800
GP Supply (FTE)	145	173	37	44
GP Demand (FTE)	149	197	38	50
% Activity carried out by GP	67.2%	60.3%	67.2%	60.3%
Non GP Clinical Activity (%)	32.8%	39.7%	32.8%	39.7%



A range of skill mix scenarios created at ELHCP; but also WEL/CH/BHR Level

	FTE		
	Scenario 1	Scenario 2	Scenario 3
GP	1,056	1,056	1,056
Nurse	418	460	502
HCA	160	160	160
Physicians Associate	143	89	48
Physiotherapist	31	64	79
Practice Pharmacist	43	34	28
Local Pharmacist	37	30	24
Care Navigator	11	10	8
Other AHP	17	15	12

DRAFT

Informs new priority supply requirements

42 new General Practice Nurses for 2017/18
44 new Physician Associates for 2017/18
Plan required around clinical pharmacists in GP
+
Locally led Care Navigator and Medical Assistant Programmes

Page 71

CEPN Transformation Programme – Funded and in train

Community Education Provider Network Transformation focus areas:

1. Retention of at risk groups

2. Carers and communities

3. Primary and secondary care interactions

4. Apprenticeships and widening participation

5. New roles/new ways of working

6. Clinical Skills

In addition, each CEPN has been asked to develop a 2017/18 operating plan to outline their full connectivity with the local primary care agenda – **these will be approved by the relevant Accountable Officer** (process started prior to inception of one AO model)

CEPN Transformation Programme

East London Health & Care Partnership

Example Programmes – City and Hackney:

Theme	Programme
Retention of the Workforce	Activity delivered as a result of CEPN primary care workforce investment April 2016/17
	Introduction of Schwartz Rounds for multi-professional staff
	Developing clinical supervision skills and future leadership potential within GP nursing
	Developing a training and development programme to support practice management roles in general practice
	Supporting salaried GPs-learning, supervision and mentoring
Clinical Skills	**Quadrant multi-disciplinary learning and development programme**
	Developing competency and capability of primary care workforce to manage service users with mental health programme avoiding attendance and admission to secondary care (City and Hackney; Newham, Tower Hamlets and Waltham Forest)
Apprenticeship & Widening Participation	Widening Participation - Creating a Pathway for Career Development from trainee to registered Nurse
Primary & Secondary Care Interactions	**Developing skills, capability and competence of primary care Nurses and their teams to facilitate learning between primary and secondary care clinicians**
	Learning Together: Strengthening integrated working between GPs and physicians
Empowering Carers & Communities	Finding the way: Skills and support programme for unpaid Carers in Hackney
New Ways of Working	**Recognising the value and contribution of implementing and developing new and existing roles in primary care**

2017/18 other workforce activities

1) Capital Nurse programme for ELHCP – focus on nurse leadership; as well as regional priorities such as preceptorship, mentorship, career offers.

2) Growing our placement capacity in all care settings

3) Clinical indemnity solutions – TST Programme

4) GP International Recruitment Programme

5) Reviewing GP training entry points; addressing the imbalance across ELHCP vs London.

6) Joint HEE/UCLP Transformation Programme:
   - Sustainable education and training systems
   - Leadership, QI and Patient Safety
   - Palliative Care
   - Mental Health
   - Digital workforce
   - Integration *(note Dartmouth activity)*
   - Carers

Note also national programmes around, for example – GPFV, MHFV

2017/18 STP investment themes – £900K HEE Fund

1) Incentivising 44 new Physician Associate Students by sponsoring their second year of study (23 last year)

2) Health and Care Careers Programme – Local events with careers advisors, teachers and job centres; 2 Care Ambassadors per borough; further development of the TST careers in care resources; ELHCP careers marketing strategy

3) First Five Year Development Programme – 18 NQ GPs/GPNs to be released for 1 session for 12 months to work on ELHCP/CCG priorities (responding to Generation Y ambitions) + be part of a leadership cohort

4) Multi-Professional QI Solutions – A small number of QI grants for staff across health and care systems to solve big ticket issues through developing multi-professional workforce solutions, as aligned to PQI Board

5) Practice Manager training – 140 Practice Managers to undertake an ELHCP Programme with a focus on Leadership Skills; Time Management; People Management; HR Law; Managing Conflict; Appraisal Skills; Financial Management; Project & Change Management; Patient Services Management (inc. demand management); Quality Control; etc…

Discussion

1) How can we truly create a workforce which can be deployed across Accountable Care Systems?

2) HEE will make available further funding to support delivery of the workforce implications of new service models – how do we determine our priorities?

3) The workforce of the future is largely here today but requires elements of re-skilling and redeployment across services and care settings - how do we develop the workforce to fit the new care models being proposed (numbers and skills)

4) Data being published shortly suggests social care recruitment and retention challenges are akin to those of the NHS – how can we better respond together?

5) How can we work together to address challenges which are outside of the control of our employers, such as a lack of affordable housing for our workers?